

***Training Manual for Health
Care Providers on Women
Centred Counselling in a
Gynaecology Clinic***



Women Centred Health Project

Public Health Department

Municipal Corporation of Greater Mumbai

Society for Health Alternatives (SAHAJ)

Royal Tropical Institute

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Training Manual for Health Care Providers on Women Centred Counselling in a Gynaecology Clinic

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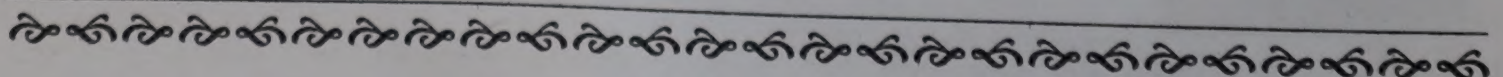
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PREFACE

This manual is the result of a unique effort to start counselling services within a Gynaecology Clinic in a municipal hospital in Mumbai. The counselling centre, an intervention of the Women Centred Health Project, is an attempt to bring gender issues into the forefront, and concepts of quality assurance within a public health system. The project, begun in 1996 is a collaboration between the Public Health Department of the Brihanmumbai Municipal Corporation, SAHAJ, a non-government organization based in Vadodara (Gujarat) and the Royal Tropical Institute, Amsterdam (Netherlands).

The counselling centre emerged in response to the need to improve client-provider communication within the outpatient clinic.

Communication with health care providers is an important aspect of "quality of care" from the perspective of poor, marginalized women seeking health services, within the urban or the rural context.

The training needs of counsellors were determined through a task analysis which forms the basis of this manual. The manual has been pre-tested with three batches of health care providers that included Auxiliary Nurse Midwives (ANMs), Male Multipurpose Workers (MPWs), Community Development Officers (CDOs) and also health care providers from NGOs. In addition to ANMs, MPWs and CDOs, this manual could also be used to train doctors and nurses in basic counselling skills and to sensitise them to women's reproductive health issues.

Several individuals contributed to the writing of this manual. Their specific contributions are separately acknowledged.

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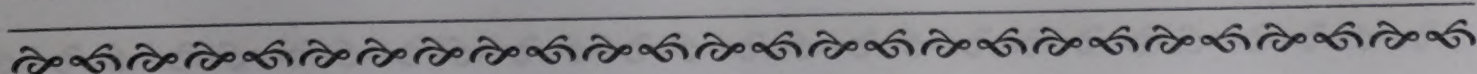
We acknowledge all the resource persons for their commitment in conducting the training sessions: Dr. Uma Pocha, Ms. Vidya Lad, Dr. Prabhu, Dr. Chitra Ramnathan, Dr. Lalita Mayadeo, Ms. Bilquees Shaikh, Ms. Sangita Punekar and Ms. Padma Deosthali

We thank the Medical Superintendent of V.N.Desai General Hospital for her support in initiating the training for health care providers in the hospital, and also for the training arrangements done by the staff of the Matron's office.

We extend our gratitude to the Medical Officers (Health) of all the participating wards for relieving staff for the training, and the Community Development Officers for making the necessary modifications in their work schedules, so that the work at the health centre did not suffer during the training.

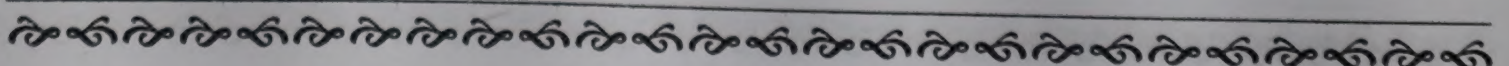
Our special thanks to Ms. Meera Limaye for organising the feedback and training workshops.

We thank the WCHP team for support in organising the training.



LIST OF ABBREVIATIONS USED

AHO	Assistant Health Officer	MCH	Maternal and Child Health
AIDS	Acquired Immuno-Deficiency Syndrome	MDACS	Mumbai District AIDS Control Society
AMO	Administrative Medical Officer	MO	Medical Officer
ANC	Ante Natal Care	MOH	Medical Officer of Health
ANM	Auxiliary Nurse Midwife	MIC	Men's Involvement Committee
BP	Blood Pressure	MPC	Module Preparation Committee
CDO	Community Development Officer	MPW	Multipurpose Worker — Male
CHVs	Community Health Volunteers	MTP	Medical Termination of Pregnancy
CME	Continuing Medical Education	NGO	Non-Governmental Organisation
D&C	Dilation and Curettage	OPD	Out-Patient Department
DEHO	Deputy Executive Health Officer	PHD	Public Health Department
FGD	Focus Group Discussion	PHN	Public Health Nurse
FHAC	Family Health Awareness Campaign	PID	Pelvic Inflammatory Diseases
FP	Family Planning	PNC	Post Natal Care
FPAI	Family Planning Association of India	QA	Quality Assurance
FTMO	Full Time Medical Officer	RCH	Reproductive and Child Health
FW & MCH	Family Welfare and Mother-Child Health	RNTCP	Revised National Tuberculosis Control Programme
FWCW	Fourth World Conference on Women	RMO	Resident Medical Officer
G/N	G/North (One of the 24 administrative wards of Mumbai)	RTI	Reproductive Tract Infection
H/E	H/East (One of the 24 administrative wards of Mumbai)	SAHAJ	Society for Health Alternatives
HIV	Human Immuno-deficiency Virus	SS	Stepping Stones
ICPD	International Conference on Population and Development	STD	Sexually Transmitted Disease
IEC	Information Education Communications	STI	Sexually Transmitted Infection
ISDT	Integrated Skill Development Training	VCTC	Voluntary Counseling and Testing Centre
IUD	Intra-uterine Device	VNDH	V. N. Desai Municipal General Hospital
KIT	Royal Tropical Institute	WCC	Woman Centred Counsellor
LSTM	Liverpool School of Tropical Medicine	WCHP	Women Centred Health Project
MCGM	Municipal Corporation of Greater Mumbai		

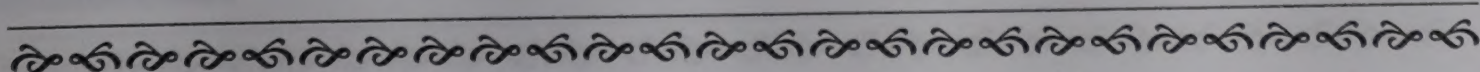


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SECTION I

INTRODUCTION AND CONTEXT

CHAPTER 1

WOMEN CENTRED HEALTH PROJECT (WCHP)

The Women Centred Health Project came about as a result of a research study commonly referred to as the PID study (Pelvic Inflammatory Diseases). The PID project was carried out in collaboration with the Brihanmumbai Municipal Corporation and the Liverpool School of Tropical Medicine (UK), and was funded by the Overseas Development Assistance (ODA) of UK. This study was carried out in 1993-96 in three locations in Mumbai to find out the social and clinical factors predisposing women to PID in the slums of Mumbai.

During the participatory research project on PID, women from the community expressed a need for services for reproductive health problems at the peripheral health care facilities, i.e. the health post and dispensaries. A group of thirty Auxiliary Nurse Midwives (ANMs) from the Public Health Department were then trained in communication and counselling skills that helped them to build rapport with the women in the community and to understand their problems. This brought out the need and importance of counselling for women for their medical and associated problems.

One of the outcomes of the PID project was learning about the actual health needs of women and their expectations from the health system:

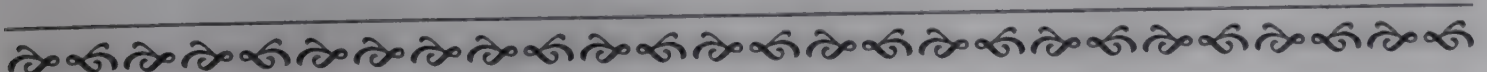
1. Women want information on the diseases they suffer from — their causes, treatment options and ways of prevention.
2. All women's health services should be under one roof - Post Partum Centres (PPC) should also have treatment and counselling for sexually transmitted infections.
3. Women want facilities for infertility investigations, treatment and support services like adoption.
4. Women want counselling and support for associated problems like alcoholic husband and family pressures related to family planning decisions.

Based on the expressed needs of women, a proposal for the Women Centred Health Project was developed to evolve a model for

- the provision of women centred health care with an emphasis on sexual and reproductive health and
- integration of need-based services into the existing healthcare delivery system.

Concept of Women Centred Health Care

"Women Centred" means that needs, values, information, experiences and issues from the point of view of women are considered and incorporated in the planning, implementation and evaluation processes of policies and programmes which affect women's lives.



Translating this concept means

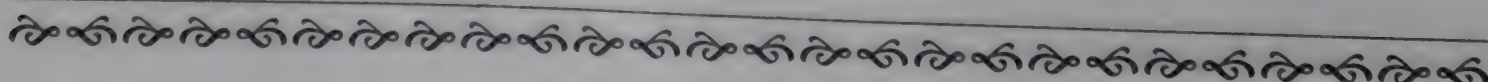
- Healthcare for women through all stages of their lives beginning from adolescence to the post-menopause stage.
- Healthcare for women for whatever health problems they identify i.e. childlessness, prolapse, and symptoms of reproductive tract infections (RTIs) as opposed to only addressing the childbearing aspect of women's health.
- Addressing gender issues which may affect women's health. This means involving male partners and addressing the sexual health of couples (together).

The plan was to implement this concept through different interventions and research activities at all levels of the existing system i.e. starting from the community to the next link of Health Posts, Post Partum Centres, peripheral hospitals and finally the teaching hospitals.

The purpose of this research-cum-intervention project entitled 'Women Centred Health Project' (WCHP) was to improve the quality of healthcare services in the MCGM health units.

The objectives of the project were:

1. To improve, strengthen and increase the quality and range of health care services for women at health posts, dispensaries as well as at secondary levels.
2. To enable women to have access to gender- sensitive and user- friendly health services.
3. To raise awareness and sensitivity on women's health and reproductive rights, gender issues, and to increase knowledge of women's health amongst men and women in the community, health workers and service providers of the MCGM.
4. To develop and build the capacity of staff in two wards of the MCGM in training, action research, monitoring and evaluation on issues related to women's health and reproductive rights.
5. To develop indicators for monitoring and evaluating quality and range of services provided.



COUNSELLING CENTRE IN THE GYNAECOLOGY OUT PATIENT DEPARTMENT

As part of its objectives of enabling women to access reproductive health services and empowering them with the necessary information, knowledge and confidence, an Information and Counselling Centre was initiated at the Gynaecology Out Patient Department (OPD) at V. N. Desai General Hospital. The rationale for the Counselling Centre emerged from the PID Study. As mentioned earlier, women in the study stated that lack of appropriate and accessible information, counselling and support services, as well as limited decision-making power within the family limited their control over their reproductive health

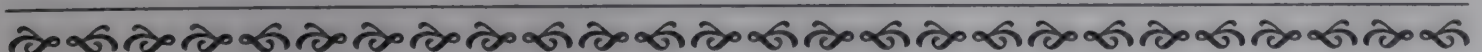
Rationale

Apart from the findings in the PID study, WCHP conducted baseline studies and a series of Quality Assurance (QA) workshops with health care providers. Three hundred and sixty-seven exit interviews conducted as part of baseline studies revealed that those who expressed dissatisfaction, though small in number, mentioned "disrespect shown by health care providers" as one of the reasons for dissatisfaction. The clients in the same study were asked why they did not question doctors when they had doubts. Responses indicated poor communication between providers and clients.

In the first Quality Assurance Workshop, health care providers identified issues related to provider-client communication styles, and health education as one of the important factors affecting the quality of services. Lack of time to talk to the patients, no counselling services, inadequate information services and sometimes language barriers were among the problems hindering provider-client communication. The participants recommended better patient information and counselling services as a part of providing good quality health care.

A pilot study to monitor provider-client communication at Kherwadi Maternity Home through Focus Group Discussions with the women attending Gynaecology and ANC OPD, revealed their perception of respectful behaviour and their expectations from health care providers. In their own words women detailed their requirements of simple and effective communication.

It was decided to undertake a similar study at the general hospital level as the dynamics in the OPD at the general hospital are different. Observations of provider-client communication patterns were started in the Gynaecology OPD of the V. N. Desai Hospital. The observation studies in the OPD showed that the quality of communication varied from person to person and even for the same person at different times, depending on other background factors such as work load, non-availability of staff, communication between the doctor and the other staff at the OPD, and socio-cultural gap between the patients and providers. Language, terminology and mannerisms used by the doctors are not understood by patients and vice-versa, adversely affecting the quality of care in terms of misdiagnosis, compliance and informed decision-making.



Box 1 : Women's perceptions about respectful behaviour and effective communication from health care providers

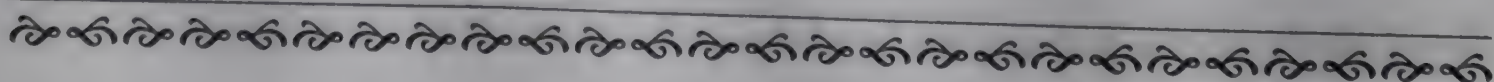
- They feel respected and less inhibited if the provider maintains eye contact while taking their medical history.
- Provider should listen patiently and encourage them to share their symptoms and other problems that they feel are associated with their condition.
- Providers should not shout at them if they sometimes are not quick at responding or understanding the information provided.
- They find it disrespectful if the provider tells them to stand or sit away from them.
- Communication would be effective if the providers use simple language and local terminology.
- Their questions should be answered patiently and instructions repeated if not understood.
- They appreciate it if they are told what is wrong with them by the provider.
- Internal examination staff needs to be more patient, as they (patients) need time to loosen their clothing and to climb on and off the examination table.

Lack of privacy and a heavy load of patients makes it difficult for the doctors to spend enough time with patients requiring counselling – women seeking services for contraception are worst affected by this. Hospital policy denies entry of men into the Gynaecology OPD to ensure privacy as involvement of husbands is seen to be unnecessary when their wives seek treatment. This, however, proves to be a negative factor for women with reproductive tract infections and sexually transmitted infections.

Lack of sensitivity towards the anxiety experienced by women undergoing internal examination, especially unmarried women and adolescent girls, can prevent women from coming for early treatment.

The observations also highlighted information and counselling needs of clients. Women needed emotional support. There was also a need to discuss sexual problems with those couples presenting with infertility. Privacy for such a consultation is not ensured in the OPD. This can discourage the couples from sharing sensitive information on their condition, leading to delayed treatment.

Women coming for termination of pregnancy (MTP) are at most times lactating mothers and they find it difficult to make decisions whether to continue the pregnancy or opt for MTP. The doctors emphasise on inserting an intrauterine device (IUD) after the MTP to prevent further unwanted pregnancies and to meet their targets. This leads to arguments between doctors and patients.



Many women come up with misconceptions, or social and family problems, that influence their contraception decisions. Providers fail to understand the real reasons and label them as 'ganwar' or 'morons'. The couples who come for MTP after the sex determination test require counselling. Sometimes the woman herself is not willing for the MTP but is being forced by her accompanying husband or mother-in-law. They wait outside the OPD while the woman seeks consultation. There is a need to talk to the decision makers and discourage them from opting for abortion.

In the absence of any information being given on gynaecological examination, many women do not follow the instructions given by the doctors. This results in them being scolded by the providers. Some women are scared of, and not prepared for internal examination and refuse to undergo the examination. Adolescent girls who come with menstrual disorders or with reports of white discharge find it difficult to give consent for internal examination. They find the OPD atmosphere inhibiting and scary. This again leads to doctors yelling at them and the girls further resist the examination. Some girls avoid the consultation.

Sometimes the language barrier affects the history taking process and the doctors fail to understand what the woman is trying to communicate and vice-versa. Insufficient information on the timings and procedures required to avail referral services for investigations and treatment, leads to delayed treatment and adversely affects the compliance.

Providers' Viewpoint

In the course of informal discussions, the providers and the administrators of the V.N.Desai Hospital felt that an information booth staffed by qualified personnel, offering patients guidance and counselling for commonly encountered situations, would help ease the situation and improve the quality of care at the OPD. Following this, an exercise (of providing information, guidance and counselling to those in need) was carried out on a pilot basis. Doctors wanted this activity to be continued on a permanent basis in the hospital as it would save them the time spent on explanations. The experience of the pilot study showed that establishing such a booth would be beneficial and ease the stress on all levels of providers as well as patients.

Establishing the Counselling Centre

The goals and objectives identified for the setting up of the Counselling Centre were as follows.

Goals

- Providing information and support to enable informed decision-making
- Providing counselling services to men partners and key family members
- Providing a safe and open environment in the formal set up of the OPD

Objectives

- To meet information and counselling needs of the clients (men and women) seeking care at the Gynaecology OPD of the secondary hospital.
- To assess feasibility, in terms of availability of space at the hospital, privacy, support from the clinicians at the OPD and from the hospital administration. This requires motivation of staff, willingness of clients to seek counselling in such a setting, and establishing a client guidance and counselling centre at the Gynaecology OPD of a secondary hospital.
- To assess the effect on client - provider communications.

Features of the Centre

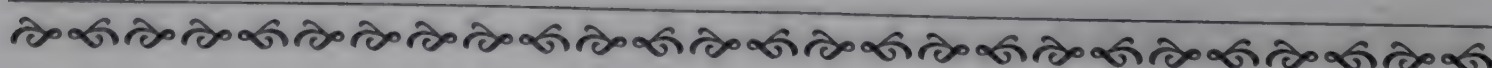
- The information and counselling centre would focus mainly on meeting the needs of those using services at the obstetric and gynaecology department in the hospital.
- The centre would be open for the duration of the OPD hours only. (9.00 am to 4.00 pm)
- Counselling would be restricted to medical and social issues associated with gynaecological /reproductive conditions only.
- For conditions / situations requiring special counselling skills, the cases would be referred to centres (NGOs/government) providing these. Such cases would include HIV positive individuals, alcoholic husband, domestic violence, marital conflicts and psychiatric problems.

Staffing

Auxiliary Nurse Midwives (ANMs) and Multi-Purpose Workers, mostly males (MPWs) from surrounding Health Posts would be trained in counselling and placed as counsellors on a rotational basis to staff the Centre. The ANMs have two to three years training in nursing and are trained in conducting deliveries. (The MPWs have completed a one-year course as Sanitary Inspectors). The reason for training these ANMs and MPWs was that they would then be able to counsel clients when they go back to their health posts and also refer patients to the Gynaecology OPD after the basic counselling done at their level.

Roles of ANMs and MPWs at the Centre would be as follows.

- a. Information-giving
- b. Counselling
- c. Link between client and doctor



CHAPTER 3

DEVELOPMENT OF THE COUNSELLING MANUAL

Task Analysis and Training Needs Assessment

The previous chapter outlined the staffing plan for the Information and Counselling Centre. A detailed task analysis was done of all those who would be associated in any way with the Counselling Centre. e.g. the doctors who would refer women to the Centre, the ANMs and MPWs who would provide counselling to the women and their partners respectively, and the nurse in the OPD who is responsible for looking after the logistics, assisting in internal examination of the patient, removing sutures, helping patients in confirming pregnancy by urine examination etc. The nurse has a very important information-giving role in the OPD. Patients often seek guidance from the nurse for locating various departments in the hospital and also regarding the prescribed procedures and investigations. Patients also consult the nurse to confirm doctor's advice, prescriptions of medicines etc.

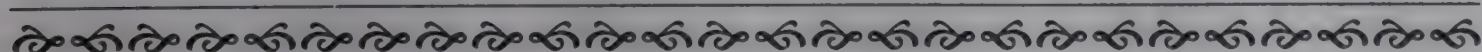
The task analysis (see Annexure I) revealed that the persons staffing the Information and Counselling Centre would require training in the following aspects:

1. Knowledge or Cognitive input

- organisation of the out patients' department : clinical specialities, doctors, timings, procedures, diagnostic services, costs and charges
- referral services : specialised services and support groups for a variety of needs such as violence counselling, child sexual abuse, sexuality counselling and so on; information regarding location of health posts and staff available at the health post
- technical gynaecological input— till a certain level— on various conditions, so that they can guide patients appropriately
- concepts like gender-based violence, sexuality and their linkages to health

2. Skills related to

- communication : giving clear information, active listening, probing, observation of non - verbal and body language, using audio visual material to explain things
- counselling
- performing a link role between the doctors and nurses in the OPD, the Community Health Volunteers(CHVs) and health post staff at the peripheral level
- training of CHVs, health post staff : participatory, experiential training
- documentation, analysis and interpretation of simple data



3. Perspective building

- to see the inter-linkages of a woman's health with her social, economic and gender background, sexuality issues and possibility of gender-based violence.
- to develop respect, acceptance, non-judgmental attitude towards all patients

Once the training needs were identified a draft manual was developed.

Preparation of a Training Manual

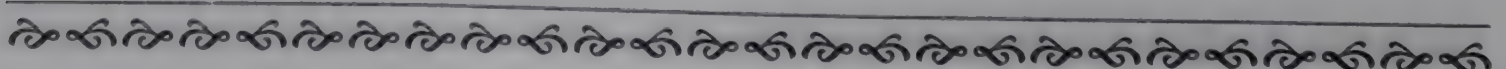
Women coming to the Counselling Centre not only require information to enable them to make informed decisions about their reproductive health problems, but also need to be counselled from a gender and reproductive rights' perspective. Many of their problems like contraception decisions, treatment for infertility, multiple abortions indicating sex selective abortions, and sexual health problems were related to gender issues. Societal expectations of women to be tolerant, obey decisions taken by family members or husband, affected her ability to assert her reproductive and sexual health rights, and in turn affected her body and health.

Therefore the project team prepared a training manual on women centred counselling. The manual would assist counsellors in developing counselling skills, and also enable them to look at women's gynaecological health problems from a gender and reproductive rights perspective, and counsel them accordingly.

The draft of the Training Manual on Women Centered Counselling was reviewed by eminent practitioners, academics, activists and clinicians from the field of Gynaecology, Preventive and Social Medicine, Sexuality, Counselling and Social Work. A two-day consultation resulted in valuable feedback in terms of content, methodologies, feasibility, possible trainers and so on. The revised manual was then field tested in three four-day training workshops for all ANMs and MPWs in one of the two project wards in 2001. For the training design of the 4-day training workshop see Annexure II. A total number of 50 health workers were trained (30 ANMs and 20 MPWs). This manual is an outcome of this long process.

About this manual

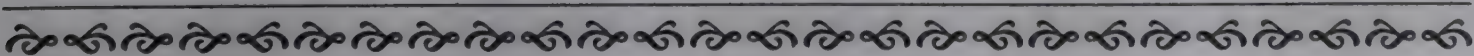
This manual contains a section outlining the perspective on which the counselling content is based. The first chapter in the Perspective section explains the gender perspective and the second chapter tries to clarify the concept of Women Centred Counselling. Section III contains session outlines which form the bulk of the manual with detailed notes on methodology for the facilitators. Handouts and exercises for the participants and contents of the overhead transparencies are included at the end of each chapter. Annexures at the end of chapters



include exercises and role plays. The annexures at the end of the manual provide background material like the Task Analysis, contents and schedules of workshops with ANMs and MPWs.

How to use this manual

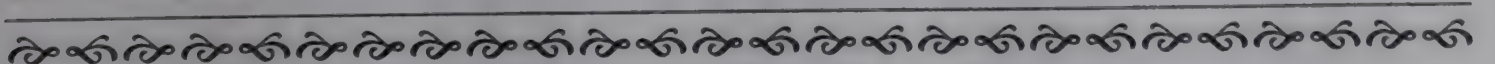
The manual can be used to train health professionals and para professionals in the basics of communication and counselling related to reproductive health conditions. This manual is not for advanced counselling for complicated issues like child sexual abuse and rape, mental health problems, domestic violence etc. It is hoped that the contents of this manual will enable the trainees to recognise the limits of their role and capacity, and appropriately refer clients who need more skilled counselling.





SECTION II

PERSPECTIVE BUILDING



What is Gender?

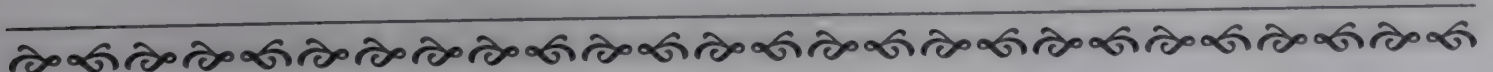
'Gender' as a concept is different from 'sex'. While 'sex' refers to the biological and physical aspects of being male and female, 'gender' refers to those characteristics of men and women that are socially determined. Most of the differences in men's and women's roles and responsibilities, norms and values that guide their behaviour and access to, and control over, resources have little to do with the fact that they are born male or female or that women can bear children. It has more to do with what society expects of them.

Gender actually works like a system. At the base are social beliefs about men and women (e.g. 'men are strong and women are weak' or 'men are rational and women are emotional') that are naturalized. These beliefs then form the basis of gender norms for behaviour and differential expectations from men and women. This in turn leads to gender roles and sexual division of labour. Access to resources and control over them is determined by gender roles. And this in turn is reflected in who makes the decisions, and who has the power to influence social beliefs and gender norms. The cycle continues.

Health conditions and health needs are determined by the interaction between biology and the gender factors described above (PAHO 1997). Thus while certain health conditions are purely sex specific, e.g. pregnancy, childbirth in women or prostate cancer in men, others are more prevalent in one sex than the other. An example of this would be anaemia due to iron deficiency linked to women's loss of iron during menstruation, pregnancy and lactation, (and exacerbated by cultural practices that privilege men in household distribution of iron rich food) or osteoporosis in women (eight times higher in women than men); and cirrhosis associated with alcohol abuse, lung cancer associated with tobacco consumption, excessive mortality from violence, homicide and accidents, in men. Yet another result of the biology and gender interaction is diseases that have different characteristics in men and women. For example, Sexually Transmitted Diseases (STDs) are 'asymptomatic' for longer periods in women, genito urinary TB in men is relatively rare, while one in eight women with pulmonary TB may also have genital TB. (Genital TB is an important cause of infertility in women in developing countries).

Finally, diseases produce different consequences and responses for men and women. For example, STDs in women can lead to sterility, nutritional deficiencies can cause maternal deaths in childbirth, malaria during pregnancy is an important cause of maternal mortality, spontaneous abortion and stillbirths. Particularly during pregnancy, malaria contributes significantly to development of chronic anaemia.

- Cardiovascular problems are considered "typical" men's diseases; as a result, these symptoms are not recognised in women. Data indicate that cardiovascular diseases are one of the main causes of death, (in some population groups the major cause of death), among women older than 49 years.



- Disfigurement due to leprosy generates greater rejection by society if the sufferer is female, given the connection between physical beauty and women's worth.
- Very few male sterilisations are done compared to female sterilisations (despite the fact that vasectomy is a simpler, more economical and less invasive procedure than sterilisation for women).
- Domestic violence towards women is judged differently from public violence against strangers and there is a greater degree of social tolerance for violence towards women from their male partners than there is for other types of social violence. This tolerance is reflected in legislation on family violence in almost every country.
- Focus of family planning services on women have excluded men, with the result that men have limited access to such services. In addition, given the gender relations within a family, decisions about contraception need to include men, otherwise women can be prevented from using them by their partners/husbands.

Gender Perspective of Health

A gendered perspective of health thus looks at the difference in health needs of men and women, differences in risk factors and determinants, severity and duration, in perceptions of illness, in access to and utilisation of health services and in health outcomes. A gender approach in health, besides looking at biological factors considers the critical roles that social and cultural factors, and power relations between women and men, play in promoting and protecting or impeding health (WHO 1998).

Frameworks for analysing women's health have typically focused on their childbearing functions, pregnancy and childbirth related issues. In addition to these special health needs, women are also exposed to all the health problems that affect men e.g. malaria, tuberculosis, leprosy etc. In fact, malaria and hepatitis become life-threatening conditions for women during pregnancy.

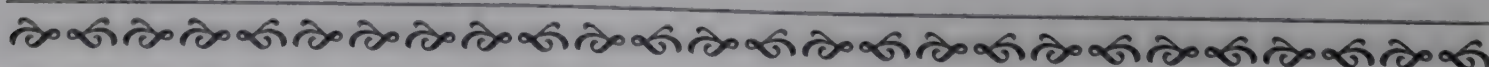
Gender Perspective in Counselling

A gender perspective in counselling will guide the counsellor to analyse the gender factors and the power relations in a client's situation. The counsellor's line of treatment will attempt to

- reduce the power differentials between any two individuals, the counsellor and the client, or the woman who comes for counselling and the 'powerful' others (husband, mother-in-law) who knowingly or unknowingly control her health-seeking decisions.
- address the social, cultural and gender factors as presented in individual clients situation.

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CHAPTER 5

WOMAN CENTRED COUNSELLING

What is Woman Centred Counselling?

Woman Centred Counselling (WCC) is an integrated and empowering approach which enables women to regain control over their lives; helps them to make choices, set goals and also encourages them to believe in, and nurture, themselves. Woman Centred Counselling does not exclude men, but addresses men in their relationship to women and their influence on women's situations.

Basis of Woman Centred Counselling

WCC is based on feminist principles. Feminist ideology defines two long term goals: Freedom from oppression (this involves freedom of choice and power to control their own lives within and outside their homes) and, Removal of all forms of inequality and oppression through creation of a more just, social and economic order with the equal participation of women in all decision-making processes.

Feminism advocates equality against oppressive systems manifested in diverse forms over time. It also stands for economic survival, physical safety and security, reproductive and sexual self-determination, and equality of status in all spheres of activities. Feminists conceptualise power in two ways – power over, i.e. domination, and power to/for, i.e. personal empowerment, which has to do with the control of one's own feelings, thoughts and behaviour. It is the latter that is promoted by the feminists.

WCC reflects the conviction that personal change and socio-political changes are inextricably linked and problems are viewed in a socio-political and cultural context. WCC is a political activity; it is concerned with changing society's attitude towards the problems of women. It believes that women's problems are not a result of their personal inadequacies, but are created by unjust and oppressive social structures. It does not encourage women to adjust to their situation; rather women are challenged to actively change it by making them more aware of their rights.

Another aspect of Woman Centred Counselling is the idea that the personal is political. The idea behind this is that the person is an integral part of the larger environment. For this reason, feminist (woman-centred) counselling should help clients place their personal experiences in a wider social context and especially explore the gender issues relating to a particular situation. This is also an argument for conducting group sessions where women share their experiences (taking away the idea that their problems are strictly individual), and to acknowledge the fact that a group can change a social environment, an individual cannot.



WCC advocates changes in society's institutions and structures so that they will allow equal treatment and opportunity for both men and women. This counselling makes women more aware of their rights, and this awareness facilitates women, or enables them to change their own situations. By involving the community, the feminist vision helps women to create an environment wherein a woman can lead a life devoid of fear and violence. To reach this stage the change has to take place in all the units of society. Involving the community is an important aspect of preventive work.

WCC counselling emphasises consciousness-raising (CR). Critical consciousness-raising and empowerment finds its roots in the black women's liberation movement where social and community raising (mostly focused on men) is combined with improving self-esteem, challenging personal internalised values and gender identities towards a process of self-realisation and self-discovery in addition to social and political action.

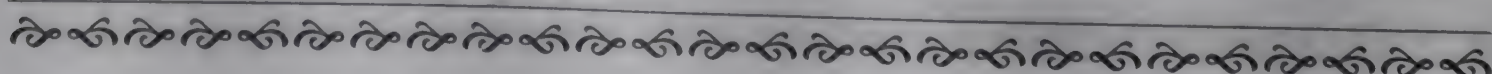
The goal of WCC is to encourage women's liberation from oppression by the patriarchal system, promote individual change and harness it towards social change. Both the counsellor and the client are involved in the process of social change.

Many women experience low self-esteem and/or dependency through their relations with men at home and at the work places. Women's strengths, courage, intelligence and know-how very rarely get valued in systematic ways. WCC gives value to the woman's own self (her way of thinking and analysis, feelings) which reveals the inner resources that she possesses. These resources will help her to empower herself. According to WCC, self-esteem is a necessary condition for effectively dealing with life's stresses. Self-esteem includes self-respect, self-authority, dignity, pride, awareness, calmness, a sense of achievement. The priority of WCC is to support other women on their road back to reclaiming their lives from a nightmare of abuse.

The work of counselling also assumes women's right to self-determination and control over their own lives. The WCC approach asserts every woman's right to be an active participant in her own healing, where she makes her own decisions. The primary commitment is to validate a woman's right to her feelings, decisions and intelligence - and also to validate her experiences. The world is seen from the survivor's point of view, the client is believed and her feelings are validated.

WCC upholds the woman's dignity as equal to a man's within the family and challenges the subordinate status of the woman in her family, thus inspiring confidence. Usually women have the experience of being silenced by their families. The process of counselling will help such women to overcome these pressures and encourage them to speak out.

WCC challenges male expectations which are based on traditional role models and stereotypes of women by introducing counterculture and different ways of looking at these stereotypes. The counselling process helps women to identify negative responses and gives practical suggestions to improve their communication. If required, significant others are also involved in the intervention process.



How does Woman Centred Counselling differ from conventional counselling?

WCC differs from traditional counselling intervention models, because feminist understanding of women's oppression and their rights is intrinsic to any assistance provided under WCC. Instead of being neutral, woman centred counsellors are pro-women. They operate on the premise that women are oppressed, exploited and are often rendered powerless in comparison to men in the present patriarchal society. Helping women takes predominance — women, due to discrimination and their "low" status, are considered more needy than men in family and society.

In WCC the major concern is the woman and her perception of the problem. She is asked to think of alternative solutions that she can accept, and then is helped to achieve what is best for herself. The conventional counselling process, on the other hand, would encourage compromise to save the institution of the family. In WCC, the woman is assured that she can reject the compromise, if she feels ill-treated. She need not adjust to the world around, but can exercise her own rights and choices.

What happens in Woman Centred Counselling?

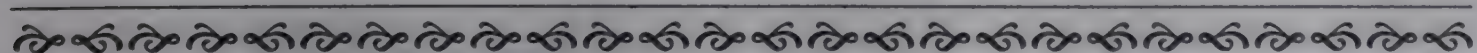
During the process of woman centred counselling, traditional stereotypes of women as passive, dependent, submissive and silent are challenged. WCC is not only limited to helping the individual woman but is also extended to questioning oppressive family structures and community pressures. The counsellor is a facilitator in the process and mainly practices two kinds of counselling methods, **crisis counselling and facilitative counselling.**

Crisis counselling

When the crisis reaches a stage when it immobilises the woman and prevents her from consciously controlling herself, the counsellor gives her psychological help and gives her a feeling of security, gives her some breathing time and space. The counsellor gives her practical help like how to file an FIR (First Information Report) at the police station, or information on a suitable shelter/short stay home. The counsellor helps the woman to reduce her anxiety, and give her hope in the situation. The psychological help is so extended that it enables the woman to review her own situation and make informed decisions based on options offered by the counsellor.

Facilitative counselling

It is the process of helping the woman clarify a problem/concern and through self- understanding and modifications in the environment, decide a plan of action and carry out that plan of action. The counsellor carefully studies and weighs the woman's situation, and offers the options available to her. Here the counsellor's focus is on helping her to know, understand and accept.



Role/Skill of a Woman Centred Counsellor

The understanding of woman's status at the macro level enables the counsellor to understand women's oppression at the micro level. The counsellor intervenes when any woman in distress approaches her-regardless of her race, ethnic origin, ability, class, etc. She is also concerned with the health status and nutritional intake of the counselled woman.

The counselling process is not done in isolation but is aligned with the social environment of the client. During this process the pro-woman counsellor challenges the client woman's individual exploitation/violation in family/community. All this is assessed by making home visits. So the home visit becomes the most important tool of assessing the social environment of the woman.

Social assistance is required and necessary at all the stages, and is offered by the counsellor in various ways, such as accompanying the woman to places like the police station, courts, government offices, medical establishments etc. In some cases the counsellor also helps the woman by providing her shelter. To empower the woman financially the counsellor arranges for training, so that she can support herself. This entire process including exposure to situations where she deals with the persons in authority. helps the woman to raise her self confidence.

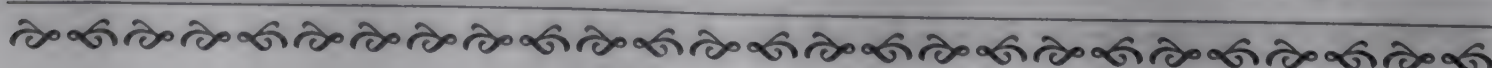
Counsellor - Counsellee Relationship

In WCC, the counselling relationship, or the power relation between the counsellor and client, is egalitarian, unlike in traditional psychotherapy and counselling techniques where the powerful position of the counsellor was critiqued. From a feminist point (women-centred) of view, the counsellor was always in a more powerful position because they did not share their own experiences and weaknesses. On that basis mutual counselling or client-centred counselling was introduced. This meant that the counsellor and the client changed roles. For professional counselling situations this is not very practical but the issue of power still needs to be addressed. The ways counsellor go about this is through: creating an enabling environment, and enabling a person to gain self-esteem and self-confidence so that they become more and more able to contradict or question suggestions/ideas put forward by the counsellor. Also the counsellor makes the contract outlining the roles of each, and agreeing to what a client can expect and demand of the counsellor.

Feminist counsellors also acknowledge that women are oppressed in different ways. Women can, and do, oppress other women. Feminist counsellors need to be aware of their own personal privileges and place in society so as not to hurt their clients.

Results of Woman Centred Counselling

WCC attempts conscientisation of women to oppose oppression in their daily lives, and to talk about their own issues. Women, whose perception of their individuality is raised, start asking questions



about being battered and realise that they need not have suffered so. Information regarding support systems is also shared here. These activities make women active participants, they form groups and act as pressure groups and help other women in the community. This facilitates women to overcome isolation and also to relocate themselves in different relationships, besides the family and community relationships.

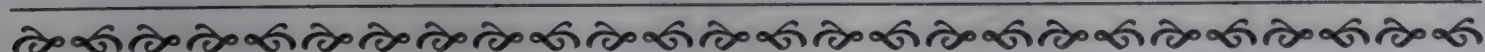
WCC increases women's vocabulary to define their own experiences and provides them objectivity about their own lives. Women are empowered with knowledge, skills, and are also helped in changing their attitudes.

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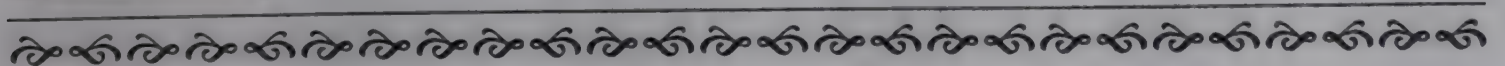
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SECTION III

TRAINING SESSIONS



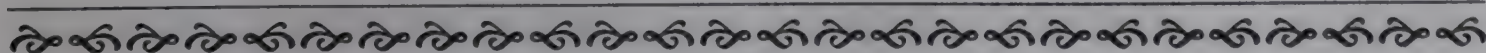
PART 1 : COMMUNICATION

Communication is a process through which people exchange ideas, facts, feelings or impressions in ways that create a common understanding of a message. Health workers need to communicate more effectively than other workers, because they deal with health problems, as they need to give and get information, and establish rapport with the community to reach decisions and solve problems. Effective Inter Personal Communication (IPC) between health care providers and clients/patients is an important factor in improving patient satisfaction, treatment compliance and outcomes. It helps to develop a rapport with the patient ensuring that diagnosis is accurate, compliance with treatment is better and follow-up is more regular. If the patient is given information about her illness, the investigations that are to be carried out, and the treatment options, and when concern is shown to her, there is bound to be greater patient satisfaction and better treatment compliance. Thus, the long term outcome would be reduction in morbidity/mortality, leading to a positive health status. While there is evidence of better treatment outcomes with effective communication skills, it is also evident that poor provider-client communication can affect the quality of health care. Unfortunately, inadequate emphasis is given to communication skills during basic Medical and Nursing training.

Effective communication may not come naturally or easily. Even though the health care provider and client may belong to the same geographical area, there may be differences in their social status, educational backgrounds and cultural background. Due to this, messages may not be interpreted correctly. Factors such as lack of privacy and time constraint also affect inter-personal communication.

It is important to understand that communication styles of men and women are different. Women communicate more through non-verbal, body language. They also tend to communicate more through metaphors or symbolic forms of expression, especially when they want to speak about their bodies. Women are not comfortable talking about sexual and reproductive issues. Health care providers, too, are not comfortable talking about these issues in day-to-day language, which is why it is important for health care providers to develop communication skills to tackle this.

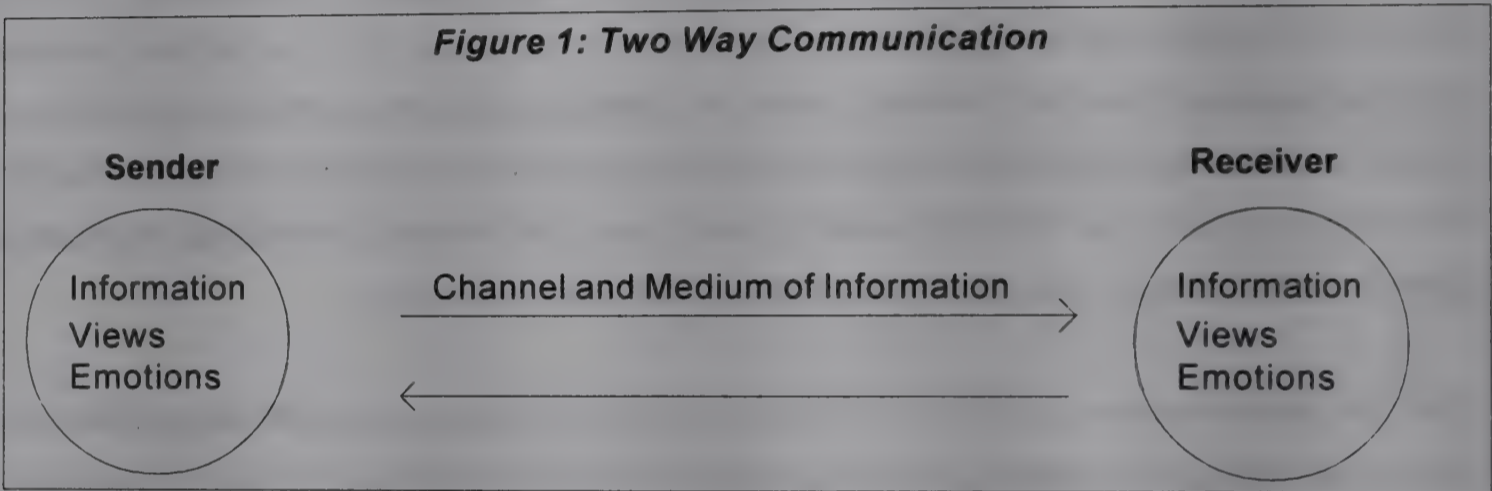
Communication styles also indicate the respect one has for others. The objective of communication should be sharing of information in a way which is understood by the woman, respecting and valuing her, and helping her to gain control of the situation i.e. empowering her. Listening to the woman and then explaining the medical facts to her in language understood by her is most important. Health care providers, by virtue of their training, tend to subconsciously use jargon while communicating with patients, which increases the feeling of inequality between the health care provider and the patient.



Health care providers have to be constantly aware that they wield considerable power in their relationship with patients. They have the power of their class, education and status, as well as the power of being perceived as healers by vulnerable, sick people. Effective communication, listening to people, empathizing with them, sharing information and enabling them to come to decisions related to their health helps in bridging the gap. It is important to remember that health behaviour varies from person to person, one household to another and one cultural/social group to another. Thus interpersonal communication is an important function of health care personnel at all levels - more so in a counselling session.

Inter - Personal Communication (IPC)

Inter-Personal Communication means sharing of words, feelings and communication between two or more people. Establishing a common interest or common meaning of words between two persons is the key to successful inter-personal communication. This communication must take place in close proximity i.e., face to face with each other and must always be two-way.



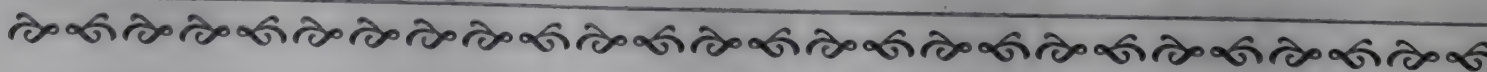
Interpersonal communication is face to face, verbal and non-verbal exchange of information, feelings, between two or more people.

In one-way communication, only the sender sends the message. The receiver, or the audience, does not interact. An example of one-way communication is a lecture. There is no feedback about whether the receiver of the message has understood the message.

In two-way communication, the sender sends the message. The receiver comprehends and understands what is being said in the message and then sends feedback to the sender. Two-way communication is always better than one-way communication because there is interaction between the sender and receiver as it allows for an opportunity to ensure that the message has been interpreted correctly.

The Communication Process

Inter-personal communication can be made effective by reviewing each component of the communication process. Components of the two-way communication process are:



Communicators

For two-way communication, there is a sender and a receiver. The sender is the originator of the message. To be effective, the sender must be clear about (i) the objective of the communication (ii) needs, interests and abilities of the receiver (iii) the content or usefulness of the message and (iv) the channel to be used. It is important that the message is sent in a language that is understood by the receiver of the message. The receiver listens to the message, has to understand its content and then respond to it.

Message

Message is the idea, feeling or information that is to be sent to the receiver. It may be verbal or non-verbal. For effective communication, the message should be clear and free from ambiguity.

Channel

Channel is the medium of communication, and can be audio, visual or both. Communication should be adjusted to local cultural patterns and cultural media, for example, use of folk lore through folk theatre, folk music etc. to communicate effectively with village folk.

Effect or outcome

These are changes that occur in the receiver as a result of receiving the message: e.g. at the end of a health education session there may be

- Changes in a receiver’s knowledge - for example, when a man is provided health education on different contraceptive methods, he may have greater awareness of different family planning methods,
- Changes in the receiver’s attitude - the man cited above now begins to appreciate the small family norm and the need to be involved in making responsible choices,
- Changes in action - the husband is now willing to undergo vasectomy instead of insisting on tubectomy for his wife.

Barriers in Communication

These are beliefs/attitudes of sender/receiver and other distracting features like noise, over crowding, heat or cold in the room. The other barriers which affect communication are socio-cultural gaps leading to differences in language, terminology and mannerisms, and structural factors like lack of privacy, workload, and lack of sensitivity by some providers to the anxiety expressed by women undergoing examination, or, during the consultation. The barriers could be external or internal.

External Barriers

- Noise/disturbance
- Ambience or atmosphere
- Time constraints for sender and receiver

Internal Barriers

For sender

- Inadequate knowledge
- Inadequate skills
- Self image
- Frame of mind
- Attitudes, mind set
- Biases/ prejudices
- No listening skills
- Inappropriate verbal or non-verbal language
- Inappropriate use of audio-visuals

For receiver

- Frame of mind e.g. disturbed or distracted mind when in pain or suffering
- Attitudes, mind set
- Biases / prejudices
- Closed to learning
- Content is irrelevant to the receivers' experiences, so he / she cannot relate to it
- Does not feel respected

Communication for Behaviour Change and Process of Behavioural Change

In a health care setting one objective of communication with clients is to bring about desirable changes in their attitudes and behaviour so that they can prevent or control the “unhealthy condition/situation”. E.g. abstinence from sex or use of condoms for prevention of STDs, avoiding getting treatment from quacks, or including iron rich food in the diet of pregnant women. Often, mass awareness strategies are employed to reach messages related to preventive measures for the community. Some health-related messages are given to people through group meetings and one-to-one interpersonal communication. Health-care providers often get frustrated that in spite of their efforts to spread awareness, people and society do not change and do not behave in a desired manner to prevent diseases. It is important to understand that public awareness about health problems and issues alone does not bring about behavioural change. Therefore it is necessary to understand the process of behavioural change.

According to a study done by Tata Institute of Social Sciences (TISS, 1992), even if 10% of the truck drivers knew about Nirodh (a brand of condom) and use of condoms, only 1% of them were actual users. It is clear that knowledge does not always influence behaviour.

Similarly, it is a known fact that smoking causes cancer but how many actually resist smoking is a big question. The process of behavioural change is presented in the following diagram.

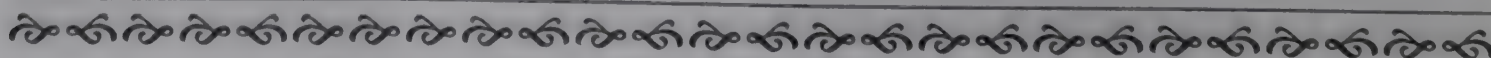
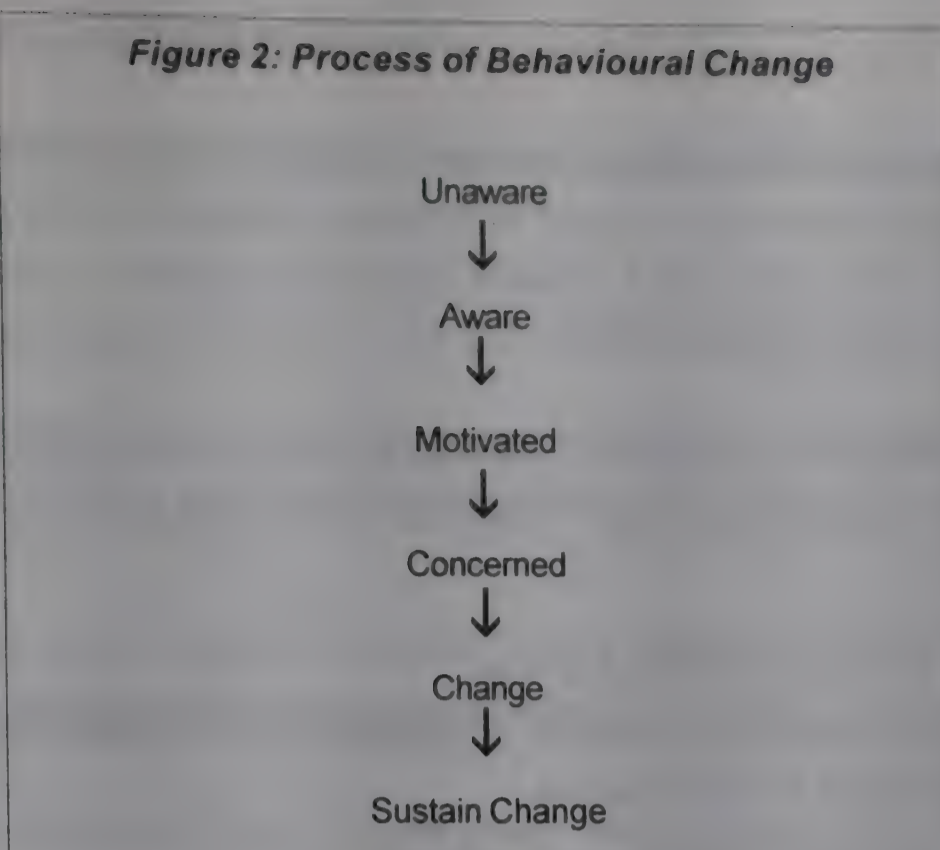


Figure 2: Process of Behavioural Change



E.g. Initially, it was difficult for surgeons to adjust to wearing gloves during surgery. But gradually they adjusted to this for their own, and patient's safety. Similarly, it is only when people realise the advantage of condoms and the dangers of diseases like AIDS, that they will use condoms. But to apply knowledge to any practice and make it a regular habit will take some time. Thus, it is not advisable to criticise people for certain habits they cannot change. Many health workers think that specific groups of people resist family planning. The health worker's attitudes get reflected through verbal and non-verbal communication. This in turn creates a block in the receivers' minds against health care providers and the health care system. Thus it is important for health workers to reflect on their attitudes and use their communication skills to understand the sources of notions and beliefs of the people, and clarify them by giving information.

Health care providers need to learn some essential communication skills and techniques for effective communication to build a rapport with the client.

With reference to communication with the client

Non-Verbal and Verbal Communication Skills

Communication can be verbal or non-verbal. All that we communicate has 70% of non-verbal and 30% of verbal communication.

Non-verbal communication skills

1. **Eye contact:** Maintaining eye contact helps to put the client at ease and helps the client to talk openly about her/ his problems. One should balance the intensity of eye contact by not staring.

Remember

- Look at the client when the client is talking
- It is okay to look elsewhere occasionally, but one should not let the eyes wander aimlessly, away from the client, for long stretches.

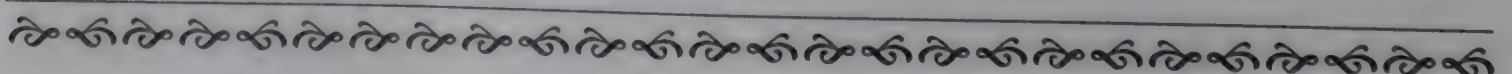
2. **Facial Expression:** Appropriate facial expressions assure the client that you are listening and responding to her talk/sharing. Sometimes clients judge whether the counsellor is accepting them based on the facial expressions of the counsellor.

3. **Body language:** Be relaxed. However, if the counsellor sits in a too relaxed position (with his/her feet on a stool/table), the client may feel that the counsellor is casual and disinterested in her/him. If your body language indicates excessive tension, the client may feel that either you are not confident about addressing her issue, or that you are impatient and find it difficult to discuss her issue. Body tension can however be used positively by leaning forward towards the client to show attentiveness.

4. **Physical distance between the counsellor and the client:** The client finds it easier to talk openly, if the distance between the client and the counsellor is 3 to 4 feet. The client may experience pressure, fear or tension, if the distance is less than 2 feet or more than 4 feet.

5. **Active listening and observation:** Listening is of two types, active and passive, and it has great impact in the process of counselling. Sometimes unconsciously, when the client comes for counselling, the counsellor may attend to the client while continuing to do her own work. The counsellor may hear what the client says, but may not be listening to what the client is saying. Active listening understands what the client is communicating, including the feelings and thoughts behind the spoken words. One cannot depend on client's verbal expression alone to understand the real problem. The counsellor needs to observe the expressions and feelings reflected on the client's face, her body language, body movements, tone of voice and the silences and pauses. Unexpressed thoughts and feelings can only be picked up through non-verbal communication.

6. **Appropriate use of smiles:** Clients feel encouraged to talk, if the counsellor smiles and nods while responding to the client. But smiling continuously or inappropriately could be interpreted as a negative response and can discourage the client from sharing.



Verbal communication skills

- 1. **Allowing the client to complete the sentence without interrupting:** If the counsellor interrupts the client while talking, the client may feel that the counsellor is trying to use his/her power to correct the client's shortcomings. However, if the client is wandering away from the subject it is necessary to intervene politely and direct the conversation back to the topic.
- 2. **Use of encouragers:** The client is assured that the counsellor is listening if the counsellor makes use of verbal encouragers like "uh..uh" , "okay, then..." during the conversation at appropriate points.
- 4. **Appropriate use of voice:** The tone of voice is important for effective communication. Counsellors should learn the skills of voice modulation, the speed of speech etc.
- 5. **Quality of information given to the client:** Using language familiar to the client is an important aspect of verbal communication. It is necessary to consciously avoid using technical words. To simplify technical information for clients is the most challenging task of a counsellor working in a health setting.

Remember

Essentials for Verbal skills

- Welcome - make the patient comfortable
- Friendly tone and voice
- Give complete information
- Invite clarifications

Essentials for Non-verbal skills

- Be relaxed
- Have an open and approachable facial expression
- Lean towards client
- Maintain eye contact
- Touch patient appropriately to communicate concern

(Source : Khanna R, Pongurlekar S, de Koning K, Training Manual for Auxiliary Nurse Midwives in Communication and Research into Women's Sexual Health Issues)

SESSION OUTLINES

Module Objectives

- At the end of this module, the participants will
- Describe the process, components and essentials of two-way communication
 - State barriers to effective communication and identify their own attitudes and biases that affect their communication
 - Demonstrate basic verbal and non-verbal communication skills
 - Describe different audio-visual aids and media used for effective communication

Session 1 Components and Essentials of Effective Communication

Learning Objectives

- At the end of the session the participants will be able to
- list the qualities required for effective communication
 - enumerate the importance of two way communication
 - describe the process and the components of two way communication
 - state the importance and use of verbal and non-verbal “communication skills” in a counselling situation

Time 1 hour

Exercise 1: **Qualities required for effective communication— Process of two-way Communication**

Time 20 minutes

Resources Black board, chalk

Methodology

1. Facilitator tells the participants to recall an individual who is a good communicator
2. Ask participants to share the recalled person’s abilities or qualities as a good communicator
3. Facilitator writes their responses on the black board

Possible Responses

- Clear speech
- Easily understood language and terminology
- Ability to express ideas and feelings clearly
- Respect for the other person
- Positive attitude
- Non-judgmental
- Open and broad-minded, frank
- Good listener
- Sensitive to the person
- Knowledgeable
- Friendly
- Showed interest
- Initiative
- Self-confidence

Facilitator's Note

The facilitator uses this exercise to explain that a good communicator has a number of good qualities. One quality common to all good communicators is their ability to reach their message effectively across to the receiver. Qualities like sincerity and empathy are always associated with effective communication.

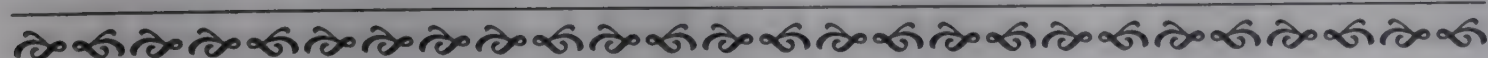
Exercise 2: Importance and Process of Two-Way Communication (10 minutes)

Time 10 minutes

Resources Few packets of condoms, OHT 6.1 showing process of Two-way Communication

Methodology

1. The facilitator distributes the packets of condoms to all the participants without communicating anything, waits for some time and observes their response.
2. Facilitator then asks the group to share their thoughts, feelings. Generally the response is that they didn't know what they were supposed to do with the condoms.
3. Facilitator explains the need to communicate effectively with clients who receive such packets. Clients should not be looked upon as targets— their information needs need to be satisfied. Hence any health education or promotion activity should provide people with an opportunity to clarify their doubts and ask questions through the two-way communication process.
4. Facilitator asks participants to define one-way and two-way communication and lists down their responses in two columns on the board.
5. The facilitator summarises the process and components of two-way communication with the help of OHT 6.1(Two-way Communication)



Exercise 3: Non-verbal and Verbal Communication Skills

Time 30 minutes.

Resources Role-play, two facilitators to enact the role play, Transparencies of verbal and non-verbal communication skills (OHT 6.2)

Methodology

1. Facilitator briefly talks about each of the following verbal and non-verbal skills, followed by a short role-play demonstrating appropriate and inappropriate ways of counsellor’s behaviour. (See Annexure 6.1 for role play situations) Facilitator explains the do’s and dont’s of each skill being enacted.

Non-verbal

- Eye contact
- Facial Expression
- Body language
- Physical distance between the counsellor and the client
- Active Listening and observation
- Appropriate use of smile

Verbal

- Allowing the client to complete the sentence without interrupting
- Use of encouragers
- Use of voice
- Quality of information given to the client:

2. Facilitator asks the group to then summarise the skills covered in that session and ends the session by showing transparency (OHT 6.2)

Remember

Skills that need to be developed for effective IPC

- Effective listening - leaning forward, eye contact, head nod, responses like - "I see", "uh-huh"
- Encourage dialogue – ask open-ended questions
- Avoid interruption
- Avoid premature diagnosis – do not jump to conclusion before hearing the person fully
- Probe for more information by asking open-ended questions
- Ask the person what seems to have caused the problem, what are the difficulties, any other worries?

Session 2 Active Listening and Non-Verbal Communication

Exercise 1: Listening pairs

Learning Objectives

At the end of the session participants will be able to

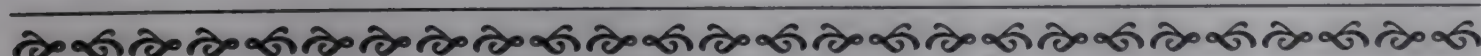
- differentiate between active and passive listening.
- describe the importance of active listening in counselling.

Time 30 minutes

Resources Room for forming pairs

Methodology

1. Divide participants into two groups 'Group A' & 'Group B'
2. Each member of Group A will pair with a member of Group B.
3. The facilitator announces that each Group A member has to narrate a happy event in his/her life to the Group B partner.
4. Facilitator takes Group B out of hearing of Group A and instructs Group B members that while the Group A partner is narrating the incident - for the first five minutes – "do not pay attention to what she/he is saying, interrupt her or be pre-occupied. For the next five minutes, listen with attention". Group B return to their partners.
5. The facilitator announces the commencement of the exercise and lets it proceed for 10 minutes.
6. Facilitator then asks members of Group A to share how they felt during the first five minutes, and then the next five minutes. Enable participants to reflect on how they felt when they were not being listened to, and how they felt when they were being listened to with attention. Group A members will generally express feeling hurt, angry and helpless when the Group B members did not listen to them carefully. These feelings are accentuated because they were talking about something personal in their lives.
7. The facilitator lists out the action or behaviours that indicate active listening e.g. eye contact, saying "uh-hun", "I-see", leaning towards the person who is talking to you, nodding of head, not interrupting, allowing the person to finish and then checking out whether what the person is saying is understood.
Facilitator draws attention to the fact that listening to the person with attention, encourages him/her to share information, promotes warm and close relationships.
8. Facilitator also asks Group A members how they felt about the non-verbal communication or body language of their Group B partner, like looking disinterested, lack of eye contact. The facilitator relates this to the health care setting, the situation with the patient.



Exercise 2: Active listening**Learning Objectives**

At the end of the session participants will be able to

- describe the importance of listening
- describe the difference between hearing and active listening

Time 20 minutes

Resources None

Methodology

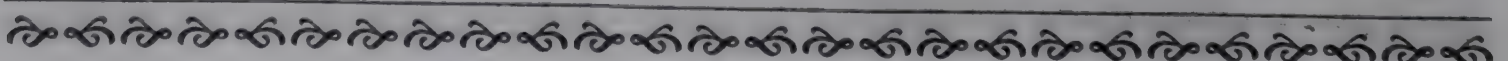
1. Facilitator tells participants "close your eyes and recollect three people you met yesterday and write down what they said to you."
2. After five minutes, facilitator asks participants to read out what they have written.
3. Generally, it happens that they write and remember more of what they said than what they heard.

Facilitator's Note

You generally tend to remember what you said to people. Often, you do not remember what others said because although the messages are transmitted, they are not listened to.

Remember***To be a good listener,***

- Be attentive - look at the speaker, take down notes for later reference.
- Comprehend what the person is trying to communicate to you.
- Absorb. If you listen carefully, you will understand what the person is saying and then you will be able to take it in. This will enable decision-making and taking action.
- Listening to the underlying feelings in any message is important.



Session 3 Being Congruent: Expression of Emotions through Body Language and Voice

Learning Objectives

At the end of the exercise, participants will

- state the different levels at which communication takes place.
- describe the need to be congruent in words and body language (i.e. both should match).

Time 30 minutes

Resource Volunteers to participate in short role-plays

Methodology

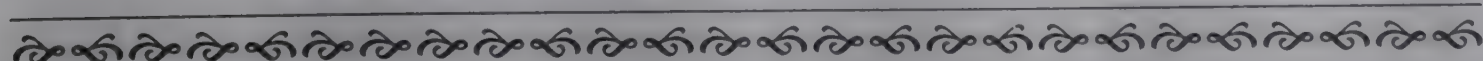
1. The facilitator enacts a few situations on incongruent communication with a volunteer from the group. The volunteer is informed of his/her role in each situation and asked to become conscious of his/her feelings in each situation.

Example 1: While saying 'welcome, welcome' to guests on opening the front door, the host does not move from the door and does not let the guests into the house.

Example 2: While saying, 'what a lovely gift', the receiver puts aside the gift without examining it.

Example 3: While saying 'I am sorry to hear that you got into trouble with your boss', the person who is saying this, is smiling.

2. After enacting these situations, the facilitator asks the participants:
 - What they observed about the levels of communication.
 - Was there a difference between the words and the body language?
 - The volunteer is asked to share how he/she felt at the end of each message and why.
3. The facilitator asks the participants to give examples of moments in their lives when they felt they were receiving double messages (superficial and hidden.)
4. The participants are asked to get into groups of 3-5 members and create situations of, incongruent communication, and then, in the same situations, using congruent communication.



Session 4 Internal Barriers to Communication

Learning Objectives

- At the end of the session participants will be able to
- describe how attitudes, perceptions and prejudices affect one's behaviour and communication.
 - describe the process of effective communication and behavioural change.

Total Time 50 minutes

Exercise 1: Effect of Perceptions and Prejudices on one's Communication and Behaviour-I

Time 15 minutes

Resources Newsprint, marker pens

Methodology

1. Ask participants to write down the first thought or word that comes to their minds associated with each of the following words. Read each word one by one allowing time for participants to write their thoughts.
 - Man
 - Woman
 - Prostitute/Commercial Sex Worker
 - Unwed mother
 - HIV positive person
 - Person not willing to use any contraceptive
 - Repeated MTP
2. Stick newsprint on the wall with the above words written on them in big and bold letters. Use separate newsprint for each word.
3. Ask the participants to share their thoughts, and write on separate newsprints as they share the associated words.
4. Discuss the connotations associated with various words and how these words reflect attitudes towards groups of persons. Ask participants to state what the consequences of such attitudes will be on communication with that particular person.



Exercise 2: Effect of Values and Attitudes on Communication**Time** 20 minutes**Resource** Copies of sheets with statements (Handout 6.1)**Methodology**

1. Facilitator gives each participant a sheet with the following statements and asks them to mark whether they agree, disagree or are 'not sure' with the statements.

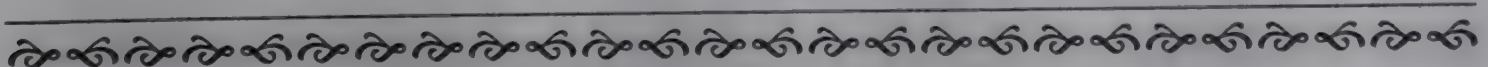
Statements

1. Unmarried people should not have access to contraception methods.
2. HIV positive people have sex with multiple partners.
3. It is all right to insist that poor families adopt family planning as they cannot afford large families.
4. Daughters should not be given freedom.
5. It is all right for boys to have sex before marriage.
6. Clients do not comply with treatment because they do not value doctor's advice.
7. Homosexuality is wrong.
8. Girls do not masturbate.
9. Sex workers are responsible for spreading HIV.
10. Girls should choose caring professions like teaching and nursing.
11. Public health system should make special provision for caring for unwed mothers.

Following the exercise facilitator initiates a discussion around the above-mentioned statements.

Facilitator's Note

There is no right or wrong answer to the statements. Each of us responds the way we do because we attach a value to each statement, which is governed by an attitude. These attitudes can be a barrier to effective communication.



Exercise 3: Effect of Perceptions and Prejudices on one's Communication and Behaviour-II

Time 15 minutes

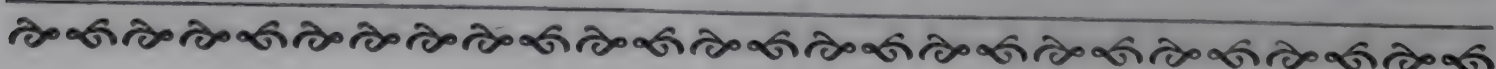
Resources A large enough room to conduct the exercise, two sets of stickers:

Set 1: Stickers in set 1 contain names of paternal and maternal relationships like grandfather, grandmother (father's parents), grandfather, grandmother (mother's parents), mother, father, *kaka*, *kaki*, *aatya* and her husband (paternal uncle and aunty), *mama*, *mami*, *mavshi* and her husband (maternal uncle and aunty) and so on.

Set 2: Stickers in set 2 contain names of various occupations/professions like teacher, doctor, clerk, air-hostess, sweeper, nurse, engineer, cook, *ayah/bai*, domestic servant, scientist, commercial sex worker and so on.

Methodology

1. Divide participants into two groups.
2. Distribute one set of stickers to each group and ask each participant to stick one label on their forehead and assume that role for the exercise.
3. Each group is asked to discuss the rank order (who will stand first in the queue till the last person) and form a single line.
4. Once the lines are formed, discuss the reasons of arrangement of a particular order. Generally paternal relatives and men in the family are placed before the maternal relatives and women. Also commercial sex worker is generally placed last in the line.
5. Discuss the issue of discrimination based on gender, class, education, kind of occupation, patriarchy etc. and ask the participants whether the attitudes towards a particular person's occupation or familial/social status affects the perceptions and behaviour of health workers towards that person. Point out that we tend to associate status, and hence respect, based on our attitudes towards people or professions. (e.g. placing sweeper at the end of the rank order) which also determines our behaviour towards that person. Therefore we tend to respect people in "respected" professions and do not respect others. E.g. in the hospital well dressed, English-speaking patients are respected and treated differently from non-literate patients. This kind of discrimination leads to hesitation and loss of confidence in poor and needy patients.
6. Discuss the need for changing the order. Facilitator points out that such perceptions and attitudes are in-built in our minds. In spite of being trained health workers we still could not do away with our biases and prejudices. Such changes take a long time to reflect in practice. Similarly at the community level, changes in people's perceptions and attitudes will take long to change, but we have to keep working towards it.



Points to Emphasise

- Our perceptions and attitudes reflect in our practice.
- We tend to discriminate based on the status associated with a particular profession or people from particular socio-economic background. Thus attitudes influence behaviour.
- Changing perceptions and attitudes is not easy and is a long process.
- One has to keep working towards it by discussing the issues and making people reflect about their behaviour.

Exercise 4: Understanding Behavioural Change Process

Time 20 minutes

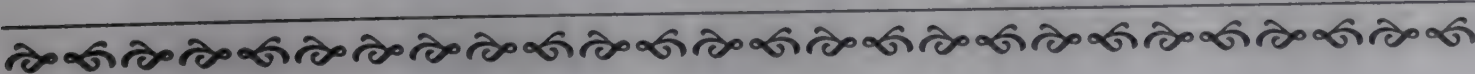
Resources Pen and paper
OHT 6.3 showing data regarding use of Nirodh among Truck Drivers and steps in behavioural change process

Methodology

1. Ask participants whether they are right or left-handed.
2. Ask right-handed persons to write their names with left hand and vice- versa.
3. Discuss their experiences and learning
4. Explain that it is not easy to give up old habits .i.e. the change that we wish to bring about in client's behaviour, will not happen over-night.
5. Ask the participants how many children would they prefer, the unanimous answer generally is 1 or 2. Explain that, as against this, the earlier generation believed in having at least 4 to 5 children in each family. It is clear that it sometimes takes a generation to realise and bring about change.
6. Present the transparency (OHT 6.3) with the truck drivers' data on use of condoms and process of behavioural change to the participants.
7. Conduct the discussion about the importance of behaviour change. Explain with the help of examples, that some of the behaviour, attitudes, and perceptions are culture and religion-based and existing since generations.

Points to Emphasise

Counsellors/health educators need to have patience with clients, and avoid a bias towards people who find it difficult to change their behaviour.



Session 5 Skills in Information Giving

Learning Objectives

At the end of the session participants will be able to

- state ways to make a health message effective and interesting.
- describe the different media for effective communication and state when to use each.

Total Time 1 hour

Exercise 1: Use of organised, logical way of providing information

Time 15 minutes

Resources

Chit (1) with a message written in a jumbled manner, e.g. daddy wants to make *pulao* (vegetable rice) so go to the market and get *kothimbir* (coriander), *jeera* (cumin seeds), rice, *kanda* (onions), *mirchi* (green chilly), *dhana* (coriander seeds), *garam masala* (spices), *potato*, *aalae* (ginger).

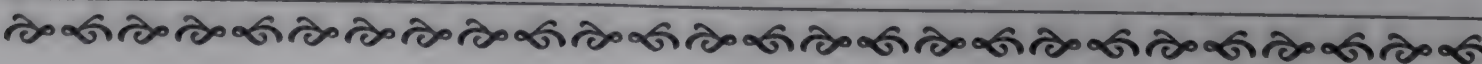
Chit (2) with the same message written in an orderly fashion, items that form one group for ease of buying are mentioned together. e.g. daddy wants to make *pulao* (vegetable rice) so go to the market and get rice, *kanda-batata* (onions, potato), *aalae*, *mirchi*, *kothimbir* (ginger, green chilly, coriander), *dhana-jeera* (coriander seeds, cumin seeds), *garam masala* (spices).

Methodology

1. Ask the participants to sit in a circle.
2. Pass chit (1) through the participants within 2 minutes.
3. Ask one or more participants to recall the message.
4. Pass chit (2) and ask them to do the same. It is generally observed that participants can recall the second message better than the first one.
5. Ask the participants for their impressions about the two different messages.
6. Brief them about how a message should be i.e. simple, crisp and logical.

Point to Emphasise

It is important to present technical knowledge in an organised and logical manner for better recall from clients.



Exercise 2: Effect of Tone, and Emphasis on Words in Communication

Time 10 minutes

Resources

OHT 6.4 with following statements written on it

"*Maro, mat chhodo!*" And "*Maro Mat, Chhodo!*"

("Kill, do not let him go !" And "Don't kill, let it be !")

"Woman without her man is nothing" and "Woman: without her, man is nothing".

"*Kam se kam chot lage!*"

Transparency showing principles of effective communication (OHT 6.5)

Methodology

1. Show transparencies with statements. Ask different participants to read each, discuss the change in the meaning of the statements with punctuation and emphasis on certain words.

Facilitator's Note

The facilitator summarises the important principles of effective communication with the help of a transparency. (OHT 6.5)

Points to Emphasise

- Emphasis on certain words in communication changes the meaning of that communication.
- It is important to pause and emphasise certain words to convey the right meaning.

Exercise 3: Using Appropriate Media

Time 30 minutes

Resource OHT 6.6, pen,

Methodology

1. Facilitator puts up a transparency showing the following

You remember 20% of what you hear	You remember 40% of what you see	You remember 80% of what you hear and see	You remember 90% of what you hear, see and do
1. Conversations 2. Dialogues 3. Lectures 4. Debates/ Discussions 5. Story telling	1. Posters 2. Leaflets 3. Pamphlets 4. Books 5. Exhibitions	1. Video 2. Cinema 3. Flash cards 4. Stories based on Flanellogram 5. Puppet shows 6. Street plays	1. Demonstration 2. Role Play 3. Games and exercises

(Source: Dr. Pocha's training session on effective IEC conducted for WCHP)

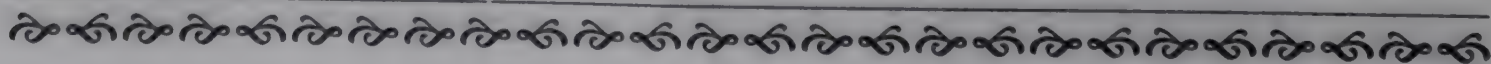
2. Facilitator should lead the discussion by giving examples of each medium of communication and advantages and disadvantages of each.

OR

2. Participants are divided into four groups. Each group discusses advantages and disadvantages of one medium of communication.
3. Questions for the group discussion could be
- What are the different media aids that you know?
 - List 3 or more advantages and disadvantages of each.
 - Which media are you comfortable with?
 - Which is the least effective medium?
 - Which is the most effective medium?
 - What are the factors that would influence you to use a particular medium?

Points to Emphasise

- To make the health education session interesting and effective one needs to use appropriate media. Participatory two-way methods like story telling, demonstration and group discussion help clients remember information better.
- Choice of media will also depend on the content, audience and the purpose of the session
- One could make use of visuals and discussion to give information on a health issue to the client during counseling, rather than just verbal information.



Session 6 Demonstration and Practice of Effective Use Of IEC Material

Learning Objectives

- At the end of the session participants will
- demonstrate effective use of IEC material like flip chart, flash cards and models of reproductive organs

Time 1 hour

Resources A set of IEC material like flip chart, models of reproductive organs, and pamphlets, copies of checklist for monitoring information session with the client. (Handout 6.2)

Methodology

1. The check list for evaluating “health education session” (Handout 6.2) is read and discussed.
2. Facilitator then demonstrates a session of giving information to the patient on any topic, either in the group, or one-to-one.
3. Participants observe the session and fill the observation checklist.
4. Points on the checklist are discussed and do’s and don’ts in the health education sessions are written on the board.
5. Two participants are then invited to give a demonstration on condom use. Others observe, use the checklist, and give feedback.

PART 2: COUNSELLING

Counselling is creating new perspectives and change within the person to enable the person to think differently about his/her own situation, or to change an aspect of his/her behaviour in order to cope with the problem that he/she is facing, or to change the conditions in the immediate environment.

Counselling is a process of communication, involving two or more persons who meet to solve a problem, resolve a crisis or make decisions involving personal intimate matters and behaviour. It encourages an exchange of information as a means of clarifying and resolving problems. Counselling is a process of building a relationship through which the client experiences confidence in the counsellor. Counselling is an interactive and continuous process. Counselling is not about meeting the client only once – the counsellor encourages the client to make regular visits if required.

Counselling is a facilitating process which enables the client to make decisions that result in a plan of action to solve the problem. Only the client can make good decisions about the situation, as only he/she knows more than anyone else about his/her own life, needs and feelings. The counsellor empowers the client to make decisions by providing clear, accurate and appropriate information. The counsellor also enables the client to apply this information to his/her life situation. This makes the relationship a vital partnership.

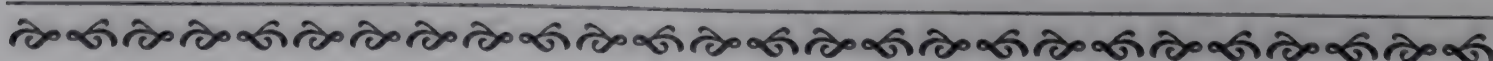
The counsellor explores along with the client, what is bothering her, and what are the stumbling blocks that prevent her from taking a decision. The purpose of the counselling session is primarily concerned with exploring facts, providing relevant need-based information to the client and thinking together about the consequences. Information should be tailored, personalised and specific in order to enable the client to make an informed, accurate and good decision. The counselling process does not end here, it further supports the client to handle his/her feelings if he/she suffers from the consequences of wrong decisions.

Counselling has both process and content components, and both are dependent on each other.

Principles of Counselling

- ***Uniqueness / Individuality of the client***

The person who seeks help shares some characteristics of the society he/she represents, but is also unique in terms of family background and coping mechanisms. The client should be made aware that he/she is a unique human being. This uniqueness must be respected at all times.



- **Unconditional acceptance**

In order to respect this uniqueness, the client must be unconditionally accepted with all his/her positive and negative behaviour, attitudes and views. The counsellor accepts the client without bringing in his/her own values, cultural background, ideologies, biases and prejudices while counselling. The client can feel this acceptance from the counsellor through body language and non-verbal communication. When the client experiences the counsellor's unconditional positive regard, the process of change gets initiated.

- **Non-judgmental attitude**

Both the client and the counsellor come from different social, cultural and economic backgrounds and different value systems. Thus a non-judgmental attitude is crucial. The counsellor may not agree with the values of the client but he/she has to allow clients the right to hold their own value system. Before exploring the background and the problem situation, the counsellor should not label or judge the clients' motivation, capacity to develop and change according to the situation. Non-judgmental attitude need not be one-way — if the client is being adamant, refuses to see other view points, the counsellor has to be forthright, but not coercive or pressurising.

- **Self - Determination**

This is an important principle of counselling. The client must always take responsibility for decision-making. The counsellor encourages the client to think of possible consequences, through self-determination and by providing accurate, appropriate information and also by providing available options. Through the counselling process the client develops the capacity of self-searching and empowerment, reflecting on any positive actions she has taken in the past and derives strength out of these.

- **Confidentiality**

This is the most important principle in counselling. Assurance for maintaining confidentiality encourages the client to verbalise his/her problem, and share medical and personal information with the counsellor, because he knows that this information will not be revealed to any other person without his prior permission.

Qualities of a Counsellor

All health care providers need to use counselling techniques as part of their work. Counselling is not giving advice or just using skills, but having certain characteristics like

- Warmth, honesty and genuine interest in the well-being of others
- Caring, positive regard
- Enthusiasm and a sense of humour
- Sensitivity and good listening skills
- Acceptance and recognition of others' qualities and capacities



- Self-awareness: Understanding his/her own limitations and biases and positive self-esteem
- Openness to learning
- Knowledge of the task and subject.
- Awareness of different cultures and practices among different people.

Self-awareness, relaxation and development

It is important to develop the desired qualities necessary to be an effective counsellor. Being conscious of one's behaviour and responses while interacting with others, and being aware of one's feelings and thoughts can develop these qualities. It is also necessary to review one's values and attitudes, discuss and obtain feedback from others, practice self-disclosure and use psychological tests and self-administered questionnaires to find out more about one's self. Realising one's strengths and weaknesses is the first step to developing the good qualities mentioned above. (Some of the self-administered questionnaires are included in the session plan).

The counsellor's own state of mind, ability to concentrate, listen patiently, and be empathetic affects the process of counselling. Unless one takes care of one's own mental and emotional state, counselling can result in burn-out. Counsellors need to be aware when they are experiencing a burn-out state and take necessary remedial and preventive action.

What is burn-out and how to prevent it

Burn-out can be defined as a condition of psychological exhaustion and diminished efficiency resulting from overwork or prolonged exposure to stress. Stress can cause a variety of illnesses, both psychological and physical.

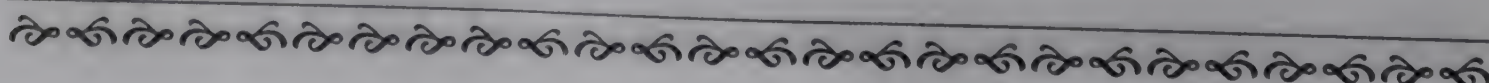
Symptoms of stress burn-out

Symptoms of burn-out can be noticed at three levels, "The physical level (characterised by exhaustion); the character level (irritability, lack of concentration, reactive attitude, feelings of helplessness); and the utility level (loss of productivity, lack of innovative decisions or actions)."

Chronic fatigue and irritability are the starting symptoms of burn-out. Eating and sleeping patterns change and one engages in escapist behaviour such as sex, drinking, drugs, partying, or shopping binges. You become indecisive, productivity drops; your work deteriorates.

Early warning signs

1. Chronic fatigue – exhaustion, tiredness, a sense of being physically run down
2. Anger at those making demands



3. Self-criticism for putting up with the demands
4. Cynicism, negativity, and irritability
5. A sense of being besieged from all sides
6. Exploding easily at seemingly inconsequential things
7. Frequent headaches and gastrointestinal disturbances
8. Weight loss or gain
9. Sleeplessness and depression
10. Shortness of breath
11. Suspiciousness
12. Feelings of helplessness
13. Increased degree of risk-taking

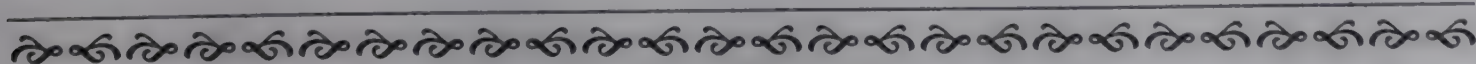
Gender and stress

It is not known if stress affects men and women differently. Generally, as the two sexes often operate in different social contexts, both tend to develop different emotional dispositions and personality traits. Accordingly, their responses and coping mechanisms to stress situations vary.

Women : Women have a lot of balancing to do between home and workplace, and between social and personal requirements. Issues of maternity, menopause, parenthood, and gender roles, familial and social support, often complicate women's lives.

Social and Work Stress : Sociological researches assert that family demands and family attitudes were found to influence employee attendance at the workplace. There is a strong relationship between social support and mental stress and trauma in women. Experiencing a high level of burn-out was associated with increased absenteeism if employees had children under six living at home or reported having difficulty with their child care arrangements.

Gender Roles : Quantity and quality of leisure time distribution between the genders is an interesting index of how women get burdened with either natural or social obligations. Women today bear a "dual burden" as both family providers and family carers. Although men and women have similar quantities of free time, when the character of leisure is considered the gap between genders re-emerges. Mothers handle the bulk of parental responsibility such as educational and emotional care of children. This can be both physically and psychologically draining.



Men : Most of the causes of male depression and stress arise from their self-nurtured identities, especially related to their professional status. "If you ask a man who he is, the first thing he says is his work—I'm an executive, I'm a doctor, I'm a house builder," says Glenn E. Good, an associate professor of educational and counselling psychology at the University of Missouri, Columbia. "Suppressing feelings and internalising stress are acquired male traits", says Good, "On some inner level, it comes down to: If I can't tough it out, then I'm not much of a man."

Work Stress : For men workplace stress can have extreme consequences. In Japan, the work-stress related suicide rate among men has risen over the last 15 years. According to the Government's Statistics Bureau, the highest suicide rate occurs in men from 35 to 44 years old, making it the 13th most common cause of death for men.

Uncertainty in the workplace can cause high levels of stress. Causes of uncertainty can be:

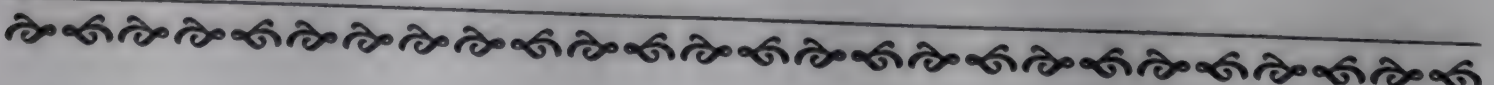
- Not having a clear idea of what the future holds
- Not knowing where your organisation will be going
- Not having any career development plans
- Not knowing what will be wanted from you in the future
- Not knowing what your boss or colleagues think of your abilities
- Receiving vague or inconsistent instructions

What is stressful for one person may not be a problem for someone else. This viewpoint leads to prevention strategies that focus on ways to help them cope.

Tips for surviving Burn-out

These tips are a way to help yourself get back on track when your stress levels are out of control.

- Re-evaluate your goals, re-set them as needed. Look closely at what you are doing and why you are doing it. How does it enrich your life? If it doesn't, change it.
- Develop a mission (purpose) for your life. Having a purpose that is value-driven helps you to put your life in perspective and set realistic goals.
- Work in a well-lit and comfortable area. Consistent exposure to poorly-lit or uncomfortable work areas leads to stress, loss of interest and excitement with your work, and ultimately burn-out.
- Take a work break every 2 hours – away from your work area. Take vacations regularly. Breaks and vacations refresh, re-energise, and re-focus us. Reward yourself for all your accomplishments big or small. No need to wait for that "big event" to happen before you reward yourself. Acknowledge the small strides and allow yourself a small reward like fresh flowers for your desk, or dinner at a favorite restaurant. If you feel overwhelmed with a project, put it aside for a while and shift to less demanding work. Pounding on the same project causes frustration and blocks creativity. Let it go for a while.



- Set realistic and do-able goals for your professional and personal life. Making your goals too difficult creates stress if you don't accomplish them; making them too easy doesn't stretch you enough and will cause you stress as well. Finding a middle ground and adjusting your goals periodically is less stressful and encouraging.
- Develop a hobby or interest in something totally unrelated to your work to create more balance. Your circle of friends will expand into other realms and give you a respite from the same, old grind.

Six ways of coping with stress

- **Keep a perspective:** it's only a job — not your life
- **Don't be a perfectionist:** you can't get things perfect every time
- **Learn to say 'No':** don't agree to take on too much
- **Delegate:** don't try to do everything yourself
- **Express:** don't bottle up feelings and emotions
- **Separate work from home:** learn to switch off

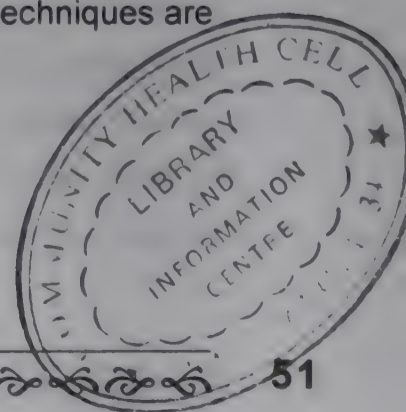
Another component of self-awareness is giving positive strokes to one's self. Instead of being unnecessarily harsh with ourselves, we can remind ourselves of those happy moments when we really felt proud of ourselves.

There are various techniques for relaxation, de-stressing and unwinding that a counsellor should learn and practice, to cope with stress and avoid burn-out. Some of the techniques are:

- Deep breathing and focusing on one's breathing
- Meditation
- Sports and games
- Fun activities like listening to music, reading
- Physical exercises and activities, like walking, jogging, swimming
- Relaxation exercises, like *shavasana*, *yoganidra*
- Sharing feelings with close friends and colleagues

Skills and Techniques used in Counselling

Every counselling situation is a unique experience, because every client is unique, has different problems which need different solutions. To make counselling effective, there are certain skills and techniques, which need to be adopted by the counsellor. Some of these skills and techniques are presented below.



1. Clarification

Use questions such as "Did you say _____?" "According to you _____?", "Was it —", to ensure that the counsellor has understood the client's message correctly. It is important to ask for such feedback from the client frequently during communication with him/her.

2. Asking open-ended and probing questions

Ask questions which will encourage the client to speak at some length and not give monosyllabic answers like 'yes' or 'no'. Questions like "Could you tell me in detail what happened?", "Could you elaborate?" encourage clients to share more information. As far as possible avoid questions beginning with 'why' and 'where'. Also avoid asking leading and directive questions.

It may be necessary to ask probing questions to get relevant information about the problem situation. It also helps to clarify certain concepts, beliefs, concerns that otherwise may not be openly shared by the client. See examples in Handout 8.2.

3. Empathy

Empathetic understanding involves accurately sensing the client's feelings and being able to see things the way he/she does. It is the ability to see and feel the world from the perspective of another person while remaining objective.

4. Reassurance

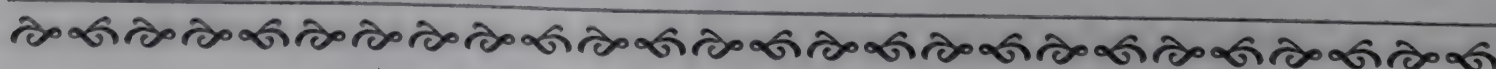
The client could be agitated, depressed or anxious so the counsellor needs to reassure the client through verbal and non-verbal communication and encourage her/him to cope by saying "Don't lose hope" or "Don't worry, things will change for the better".

5. Summarising

Clients who are disturbed and experiencing mental or emotional shock tend to talk faster, and about many things at the same time. They are also searching for answers, which may lead to a confused state of mind at the end of the counselling session. The counsellor should summarise the issues and clarify things with the client to ensure that the counsellor has understood correctly. As the last step in counselling, the counsellor lists out all the important and main points of the discussion.

6. Recapitulating

Asking the client to recapitulate the information given is usually done in a concluding session, after information about an investigation or treatment procedure is given to the client. This serves a dual purpose. **One**, it gives the counsellor a chance to find out if the information has been understood by the client. **Two**, it helps to gauge if the client is listening to the information being imparted or is pre-occupied with his/her own thoughts.



1. Paraphrasing of content

To paraphrase is to say the client's words and thoughts in your own words.

Client : I know I shouldn't be so hard on myself. But I can't seem to stop blaming myself

Counsellor : You are aware that being critical of yourself isn't helpful, even though you haven't found a way to stop doing it.

2. Reflection of feeling

Counsellor reflects the client's feelings, in her own words, to reassure the client that the counsellor has understood her/his feelings accurately. It also helps the client to recognise her feelings.

Client : I feel very agitated about how my husband is treating me and I really don't know how to change him.

Counsellor : You seem to be very angry with your husband because of his behaviour towards you. You also seem to be worried about how you can help him change this behaviour.

3. Appropriate use of silence

Silence in a counselling session gives the client an opportunity to reflect, integrate feelings, think through an idea, or absorb new information. It is not always comfortable to allow the silence to continue, but the counsellor should not interrupt prematurely because of his/her own discomfort.

Client : How could this happen to me? What have I done to deserve this? (begins to cry, looking down)

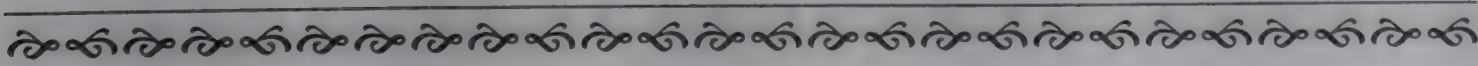
Counsellor : (softly after 10 to 15 seconds) Would you like to talk about this?

4. Focussing

Counsellor should help the client to focus his/her thoughts on the most important issue on hand. The aim of focusing is to prioritise what needs immediate attention.

Client : My daughter is not well... You know, I went to my native place and my uncle died. He was very fond of my daughter. He left the land in my daughter's name. So I was busy with getting the paper work done. I am going back next month. We have a big house in the *gaon*.

Counsellor : Okay, now, shall we come back to your daughter's health? I think you want to discuss that.



5. Confrontation

Confrontation is honest feedback to the client about inconsistencies in her behaviour, action or communication, and this needs to be completely non-judgmental.

Client	:	No one in my office likes me, there's no one I can talk to.....
Counsellor	:	Now that's an exaggeration, surely.....

What is good counselling?

Good counselling consists of two elements

1. Establishing a trusting and caring relationship with clients.
2. Giving and receiving relevant, accurate information to help client make decisions.

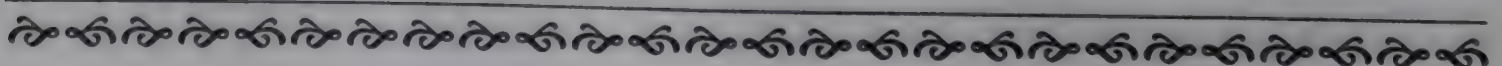
What counselling is not

Counselling is not telling a client what to do. A counselling session is not a question and answer period. It is not a forum for the presentation of the counsellor's values.

Errors In Counselling

- Directing
- Labelling
- Moralising, preaching
- Giving false reassurance
- Denying client's feelings
- Encouraging dependence
- Breaking confidentiality
- Interrogating

Now let's look at different models of counselling relevant to counselling situations in the health set-up.



Models of Counselling

Model 1: GATHER

Elements/Steps of Counselling

Counselling has six elements or steps, encapsulated in the word **GATHER**. Each letter is meaningful and helps in progressing the process of counselling.

G : Greet the client - It is the first step towards comforting and respecting the client, enables rapport building and expresses friendliness towards the client.

A : Ask - Enable the client to put into words the problem he/she is facing. Asking open-ended questions helps the counsellor in gathering the facts of the problem and exploring details. It encourages the client to express his/her feelings which in turn will enable him/her to identify the problem.

T : Talk - List the different options or enable the client to list these options. Give the client accurate, tailored and personalised information about options available to him/her. The information given to the client will enable informed decision-making and will also enable the client to review the situation in different dimensions.

H : Help - Help the client to think about the positive and negative aspects of each option and to assess the results of choosing each option. Enable the client to take the right and appropriate decision which suits his/her situation by making use of available resources and support systems. Also support the client to handle his/her feelings, if he/she suffers from the consequences of wrong decisions.

E : Explain - Explain how to carry out the decision: to 'fragment' the problem in various stages, then prioritise the problem, and then plan action to solve the problem. Also enable the client to adopt new behaviours.

R : Return - Return for follow-up. Arrange for referrals in case the required help is not within the purview of the counsellor.

Model 2: Woman Centred Counselling

Instead of being neutral, woman centred counsellors are pro-woman. They operate on the premise that women are oppressed, exploited and are often rendered powerless in comparison to men in the present patriarchal society

Values and Ethics in Woman Centred Counselling

Woman centred counselling:

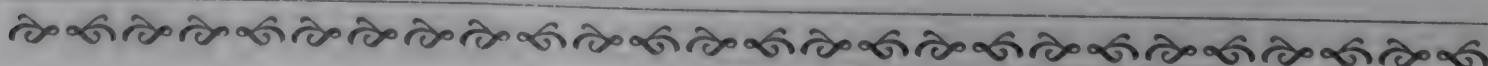
- believes that women's problems are not a result of personal inadequacies, but created by unjust and oppressive social structures.
- does not encourage women to adjust to their situation... women are challenged to become aware of their rights.
- advocates changes in society's institutions and structures to allow equal treatment and opportunity for both men and women. Change has to take place in all the units of society and involving the community is an important aspect.
- leads to improving self-esteem, challenging personal internalised values, and gender identities, towards a process of self-realisation and self-discovery
- challenges male expectations which are based on traditional role models and stereotypes of women by introducing different ways of looking at these stereotypes.
- gives value to the woman's own self (her way of thinking and analysis, feelings)
- assumes women's right to self-determination and control over their own lives.
- asserts every woman's right to be an active participant in her own healing, where she makes her own decisions.
- validates a woman's right to her feelings, decisions and intelligence - and her experiences.

The process of woman centred counselling

- challenges the subordinate status of the woman in her family and inspires confidence in her. (Usually women have the experience of being silenced by their families).
- helps the woman to break her oppressive support system in life-threatening situations.
- helps women to identify negative responses that break communication and gives practical suggestions to improve communication.

Counsellor - counsellee relationship

- In WCC, the counselling relationship or the power relation between the counsellor and client is egalitarian. Counsellors share power with their clients to make the relationship more equal by discarding the notion of "us" (counsellor) and "them".



- Feminist counsellors also acknowledge that women are oppressed in different ways. Women can and do oppress other women. Feminist counsellors need to be aware of their own personal privileges and place in society so as not to hurt their clients.

Model 3: First Aid Counselling

First aid counselling is giving immediate help, emotional support, providing guidance and referring the client to the appropriate agency. This is important in a clinical setting because at times client comes with physical/sexual abuse or after a traumatic situation like miscarriage, or loss of child. In such a situation it is necessary to use some additional skills apart from the skills presented earlier.

Emotional support – giving the client a feeling of genuine concern through verbal and non-verbal responses.

Receiving information – trying to find out as much as possible about the problem without any prejudice or bias.

Reality orientation – Taking a practical view of the problem, clarifying fantasies.

Anticipatory guidance – Mentally visualising and taking stock of foreseeable consequences and what to do about them.

Role-playing – is linked to anticipatory guidance and means enacting the anticipated event. The foreseen events may be acted out so as to try out different roles. For example, if a girl knows that when she becomes 16, her parents will insist that she gets married, she can enact how she will respond, how she will try to convince them to delay her marriage.

Motivation – Motivating the client to take action to solve the problem.

Reflective discussion – This is discussion between the counsellor and the client based upon the client's reflection on different areas of his/her life that may have some bearing upon his/her problem. Reflective discussion promotes analytical thinking on the problem.

Correcting perceptions – Clarification can lead to a change in the understanding of particular situations.

Modeling – Modeling means setting an example through one's own conduct. Clients do learn from what the counsellor says/does. Since the counsellor converses purposefully and responsibly, some clients learn helpful and constructive ways of communication from their interaction with the counsellor.

Removing guilt feelings – Removing guilt feelings is essential so that the client can participate in the problem-solving process.

Using guilt feelings constructively – Guilt feelings are warranted and realistic when they result from behaviour which causes harm to oneself or others, and is socially unacceptable. In such circumstances the client can be enabled to use his/her guilt feelings constructively for changing his/her behaviour. For example, Farah who went to see a film without informing her mother and bunking her tailoring class, may feel guilty about her behaviour. This guilt can be used to make her realise her mistake and generate insight and awareness so that she will not repeat the same act.

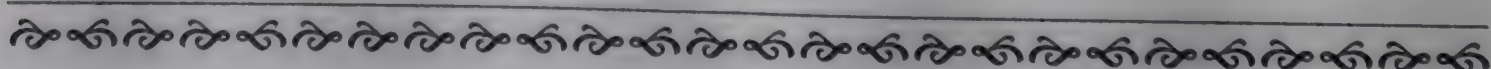
Partialisation – means dealing with the most immediate problem first and reserving the rest for discussion later. Sometimes the client may prioritise the problematic aspects wrongly, in which case the counsellor has to enable him/her to think over and correct his/her perception.

Interpretation – is the explanation of the client's behaviour in terms of its psychological meaning. For example, Shashi is a 14-year-old girl. Suddenly she started wetting her bed. When the case history was taken it showed that this phenomenon started after tension between her parents escalated and they started discussing separation. This may indicate onset of insecurity in the girl, and due measures can be taken by the parents.

Universalisation – means making the client aware that others too have similar problems. Some times the client may think that he/she is the only one who has a particular problem and hence experiences excessive anxiety, self-pity. Universalisation enables one to overcome such anxieties and self-pity. For example, if an adolescent girl feels that the anxiety or fear about growing up is unique to her, we can assure her by saying that all of us go through a similar phase. This will help to reduce her anxieties and face the changes more confidently.

Setting limits – The concept of acceptance does not mean that every kind of behaviour has to be accepted or condoned. The client as an individual has to be accepted unconditionally, but his/her behaviour may be approved conditionally and hence setting limits to certain types of behaviour is important. For example, if a girl has a habit of using abusive language, limits can be set on the use of language. This setting of limits becomes essential when working with adolescents with behavioural problems.

The above skills and techniques can be used in combination as required in a counselling situation. The counsellors, should be careful however, that they do not encourage dependency, but instead, empower women to take control of their lives. Counsellors also need to be conscious of 'transference' ie. getting emotionally involved with the client and fighting the problem as her (the counsellor's) own, or losing rational thinking and feeling extremely upset when she cannot do much in a difficult situation. In all such situations it is advisable to refer the client to another counsellor or institution.



SESSION OUTLINES

Module Objectives

Learning about Counselling Principles, Skills and Techniques, and Values is not very easy. The aim is to encourage people to get involved in the counselling activity, to encourage them to think about their own behaviour and also to understand behaviour of clients.

It is important that each activity or session should be worked through slowly and should be aimed at encouraging the participants to observe minutely what happens in the session and reflect and react on the process freely. The participants should be able to apply and transfer these skills and principles in real life situations.

It is also important to work on one's own self as a counsellor. Thus the first session in this section is about knowing one's self, to increase self-awareness and to understand one's biases.

At the end of these sessions, the participants will be able to

- Describe the Principles of Counselling, and Ethics and Values in Counselling.
- Analyse what is not counselling and reflect on errors in counselling
- List their strengths and areas for improvement as a good communicator and counsellor
- Demonstrate basic skills and techniques used in counselling

Session 1: Sensitivity in counselling and qualities of a counsellor

Learning Objectives

At the end of the session, participants will

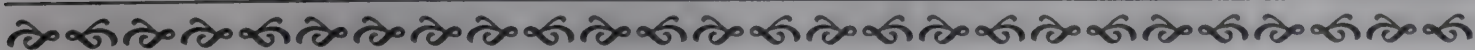
- experience feelings related to talking about their personal experience to others, and be able to relate the experience to the counselling process
- list the qualities of a counsellor.

Time 1 hour

Resources "Sensitivity exercise" for participants, black board and chalks.

Methodology

1. The participants are told to find a partner who is not known to them, with whom they would have to share a personal experience.
2. After the participants choose their partners they are told that the women would have to share experiences about their "first menstrual experience," and the men about their "first ejaculatory experience", with their partners.
3. The participants are given 10 minutes to do this.



4. Each pair then, talks about how they felt, sharing this very personal experience with their partner in the larger group. (Facilitator emphasises that they are not required to talk about the content of the experience).
5. The feelings that they experienced are listed on the blackboard and this then leads to an open discussion on how clients feel when they go to a counsellor who is a stranger. The barriers that the client could experience are discussed (like talking to a person of opposite sex, to a stranger, to a known person).
6. The facilitator then asks the participants what qualities they would look for in a person to share such a personal sensitive experience.
7. The facilitator writes participants' responses on the board in 3 columns without naming them. The columns could be for qualities, skills and principles. Facilitator helps participants to distinguish between the three aspects. The participants are then asked for their inputs, so that each of these three categories is conceptually clear to the participants.

Session 2: Self-Awareness, relaxation and development

Learning Objectives

- to enhance self-awareness as a counsellor.
- to identify strengths and weaknesses
- to enable self to become stronger

Time 70 minutes

Exercise 1: Relaxation technique-Sukhasana

Learning Objectives

At the end of the session participants will be able to

- state the importance and advantages of the relaxation techniques
- practice techniques of relaxation
- list barriers to concentration and relaxation

Time 10 minutes

Resources Mats or Durries

Methodology

1. Facilitator explains that self-awareness is a very subjective process; hence it requires effort from the individual's side. One can give of one's best only when one is relaxed, tension-free. To achieve this, we can start with *Sukhasana*.

2. Ask the participants to sit on a mat cross-legged.
3. "Close your eyes and concentrate on the tip of your nose. Try not to think about anything".
4. Try this *asana* for 5 minutes.
5. Facilitator explains that initially this *asana* can be done for 5 minutes but then can go up to 30 minutes every day.
6. Facilitator also shares advantages of regular practice of *yogasana*.

OR

1. Ask the participants to sit relaxed in a chair and close their eyes.
2. Give instructions to concentrate on the toes first. Move the attention gradually through each part of the body, till you reach the crown of the head. Then give instructions for concentration on their breathing for 5 minutes.
3. Gradually ask the participants to open their eyes.
4. Ask them to share how they felt, whether they could concentrate, or what prevented them from concentrating.

Facilitator's Note

1. Through regular practice of this exercise one can improve endurance and tolerance levels – these qualities are very useful for counselling, as counselling requires patience.
2. Counselling also requires attention and active listening. With the help of *sukhasana*, we can increase concentration.
3. It also helps in understanding barriers in our thinking process.
4. It helps in becoming aware about physical discomfort – physical discomfort and talking are closely related. When one is in great physical discomfort, one cannot communicate properly.
5. *Sukhasana* is the first step of making one's self comfortable, and in tune with the self – to alleviate physical discomfort, one can also practice *vajrasana* and *shavasana*.

Exercise 2: SWOT Analysis

Learning Objectives

At the end of the session participants will be able to

- identify their own strengths and areas for improvement
- distinguish between threats and opportunities and relate these to self-realisation and enhancing one's strengths

Time 10 minutes



Methodology

1. Facilitator gives the questionnaire to each participant to fill up.
2. Facilitator tells them that they don't have to share the results if they don't want to. It is for their personal use.
3. Ask them to write the first thought that comes to their mind and to be as truthful as possible.

- 1) I am good at _____
- 2) Because I am a girl/boy _____
- 3) The best thing that I like about myself _____
- 4) The thing that I hate about myself _____
- 5) I feel that I can not _____
- 6) I feel that I can not do it, but I could do it if _____
- 7) I feel very insecure when _____
- 8) I feel very secure when _____
- 9) I can talk freely about _____
- 10) I feel shy about _____
- 11) I could have achieved something if _____

Key-

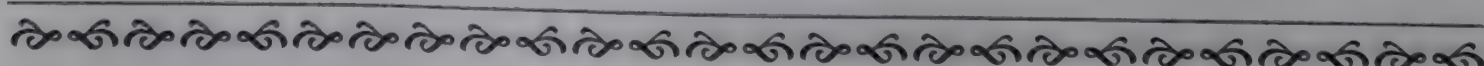
1,2,3,8 denotes your **Strength**

2,4,5,10 denotes your **Weakness**

6,9,11 denotes your **Opportunity**

7 denotes your **Threat**

4. The facilitator emphasises
 - That strength, weakness, opportunity and threat are subjective issues.
 - They change over time – what is a threat today, can be an opportunity tomorrow. The same is true with strength and weakness.
 - Remember that strength, weakness, opportunity and threat depend on our viewpoint. If we consider something as a threat, then it will never be looked upon as an opportunity but continue to be a threat. E.g. A person who is afraid of public speaking is given a chance to speak in public, but if she considers it to be a threat, she'll never overcome that fear. However, if she considers it to be an opportunity, her whole perspective will change
5. Facilitator asks the participants to take the questionnaire home and keep adding responses, weekly or monthly, to become more aware of themselves and see their threats changing into opportunities.



Exercise 3: Self-awareness questionnaire

Learning Objectives

At the end of the session participants will be able to

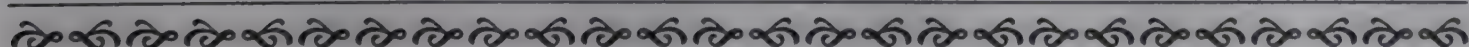
- learn how to be aware of self-image
- identify the areas for improvement to develop positive self-image

Time 20 minutes

Resources Photocopies of questionnaire (Handout 6.4)

Methodology

1. Facilitator gives the following list of qualities to each of the participants
2. Facilitator asks them to mark themselves out of 100 for each of the sentences
 1. Self-acceptance. (I like myself)
 2. Ability and presence of mind to speak the right thing
 3. Ability to express myself
 4. Competence on the job
 5. Enjoying meeting people
 6. Competence in managing my time
 7. Enjoying doing the work
 8. Engaged in continual self-development
 9. Knowing what is good for me and can assert myself
 10. Remaining always cheerful
 11. Enjoying being close to nature
 12. Ability to create trust in others
 13. Capacity to earn
 14. Capacity to imagine new possibilities and alternatives
 15. Courage to change and form new habits
 16. Self-reliance
 17. Maintaining a healthy family relationship
 18. Controlling my behaviour
 19. Being in touch with my feelings
 20. Self-confidence
 21. Capacity to relax
3. Ask them to add their scores and divide the sum by 21, which will give them their self-image score
4. Ask the participants to reflect on their weak areas and to develop action plans to improve what bothers them the most.
5. To sum up the session, the facilitator reinforces that self reflection can help us overcome our weaknesses and enhance our self-image.



Exercise 4: Personal Effectiveness

Learning Objectives

At the end of the session participants will

- know their personal effectiveness in the area of openness and getting feedback.

Time

30 minutes

Resources

Copies of Questionnaire on personal effectiveness (Handout 6.5.), OHT 6.7 on Johari window

Handout 6.6 on Johari window

Methodology

- All participants are given the questionnaire (Handout 6.5.)
- The scoring process is explained
- Each participant calculates and reflects on their scores
- Discussion is held on improving personal effectiveness with the conceptual framework of Johari window (OHT 6.7)

Session 3: Errors in Counselling

Learning Objectives

At the end of the session participants will be able to

- list the don'ts in counselling in terms of principles and values

Time

20 minutes

Resources

Role-play (Annexure 6.2),

OHT, Transparencies (OHT 6.8),

Black board and chalk.

Methodology

1. The facilitators do a five-minute role play showing the errors involved in counselling (participants are not told what they will see in the role play). Participants are told to record their observations.
2. After the role play participants are asked to share their observations.
3. Facilitator lists their observations.
4. The facilitator will then put up the transparency, which lists the errors and correlates each error with the role-play. (OHT 6.8)
5. A summarisation of all the errors is done at the end of the session.

Session 4: Choice—the client’s right

Learning Objectives

- At the end of the session participants will
- be able to describe client’s ‘right to make a choice’ in a counselling situation
 - understand the important and basic principle-that clients should not be forced or coerced (unless he/she is in a death and life situation)

Exercise 1: Who can eat faster

Time 20 minutes

Resources

Packets with a mix of eatables (spicy potato chips, caramel centred chocolate, hard boiled sweets, soup stick, peas(*chana*), biscuits

Methodology

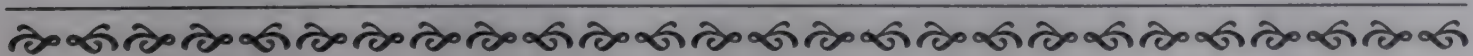
1. Divide the participants into pairs and form two groups — group A and group B. Some pairs should be same sex; others have a man and a woman.

Part 1

- a. **Instructions for group A:** You have to feed the contents of this packet to your partner. You are to ensure that your partner eats every thing in the packet in two minutes. If she/he refuses, force her/him to eat. You (the pair) will be the winner if you consume all items in the shortest period.

Part 2: To be conducted after first part is over

- b. **Instructions for group B:** Now group B will feed their partners from group A. You will hold the box in front of her/him and ask her/him to eat anything s/he likes from the packet.
2. Ask members of both groups to stand facing each other to form random pairs.
 3. Distribute packets with eatables to each participant.
 4. Conduct the exercise in two parts
 5. Ask each group to share their experiences
 6. Ask specific questions about experiences related to
 - Being fed by a person of opposite sex.
 - Feeding a person of opposite sex
 - Being forced to eat(generally it is observed that participants who are forced to eat do not like the experience and do not complete the exercise within the given time. (2 minutes)



7. Ask the participants what they learnt from this exercise and whether they can relate this situation, to the information given to clients who approach them for advise in the community or health centre.
8. Facilitator summarises by emphasising importance of giving choice to people in a counselling situation

Facilitator's Note

1. Generally health care providers want to give information/advise about all possible diseases and programmes at one time. Often, the information does not match peoples' needs so people avoid taking help, or asking for advise from health care providers. The health education campaigns and programmes too, are general and not streamlined for each individuals problems.
2. As we saw in part 2 of the exercise, people were much happier and could finish in time because they had a choice about what to eat first and at their own pace, rather than being forced to eat everything by someone else.
3. Analysis is also done about feelings of female clients when they are expected to take advise from male workers and vice-versa (many participants do not attempt the exercise because they feel shy about feeding a person or being fed by a person of the opposite sex).
4. Also in the second situation all the items were kept open in front of the partner for him / her to plan how to begin eating.

Points to Emphasise

- The clients should be clearly shown all the alternatives available
- The role of the counsellor is to suggest alternatives and enable/let the client choose.

Exercise 2: Giving direction

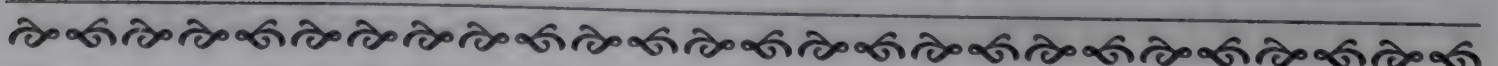
Time 10 minutes

Resources

A situation where participants can offer some advice

Methodology

1. Read out the situation: "I need some help. I have just received a message that tomorrow at 9.30 a.m. I have to attend a training programme at municipal school at Chembur. I stay at Bhandup and am not familiar with Chembur. Can anyone please tell me how to reach there?" (Change the places to suit the city)



2. People tell different routes to reach the place, including different modes of travel, costs and time involved in reaching the place.
3. Facilitator then chooses a route that is more economical or faster or easy to access.
4. Facilitator asks participants to relate the situation to a counselling session where the client is seeking advice from the counsellor and counsellor gives more than two options to deal with the problem. The client will choose what suits her best.
5. Summarise — that all ways suggested by the counsellor might be correct and might help the client solve the problem, but the choice is the clients.

Facilitator's Note

If possible probe for more than 3 answers.

Points to Emphasise

The client should be given alternatives to choose from.

The role of the counsellor is to suggest alternatives and enable/let the client choose.

Based on information given, client will choose what best suits him/her .

Session 5: Macro and Micro skills in Counselling

Learning Objectives

At the end of this session participants would be able to

- identify the “macro” and “micro” skills in counselling.
- demonstrate the skills in role play situations

Time 1 hour, 15 minutes

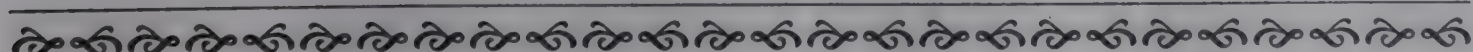
Resources Transparencies of macro and micro skills (OHT 6.9).

Methodology

1. Facilitator briefly talks about each of the following macro and micro skills giving examples of each skill with the help of a transparency.

Micro Skills

- Clarification
- Asking open-ended and probing questions
- Empathy
- Re-assurance
- Summarising
- Recapitulating



Macro Skills

- Paraphrasing of content
- Reflection of feeling
- Appropriate use of silence
- Focussing
- Confrontation

2. A few volunteers are invited to form a pair and demonstrate use of the micro and macro skills in the form of a short conversation between any two people (like friends, parents, spouses etc.)
3. Facilitator asks the group to then summarise the skills covered in that session and end the session by showing transparency (OHT- 6.9)

Session 6 Demonstration of counselling skills

Learning Objectives

At the end of this session the participants will

- state how various skills of counselling are to be used.

Time 60 minutes

Resources Role-play, Annexure 6.3, black - board, chalks.

Methodology

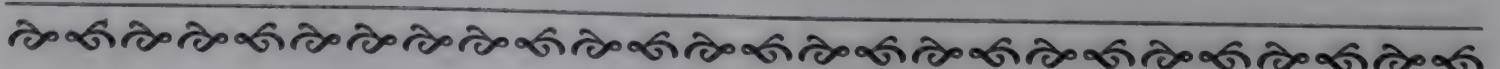
1. A twenty-minute role play is enacted by two facilitators, which covers the non-verbal, verbal, macro and micro skills. (see annexure 6.3 for role play).
2. Participants are divided into 4 groups and each group is asked to observe non-verbal, verbal, macro and micro skills respectively.
3. Facilitator makes 4 columns on the black board – non-verbal, verbal, macro skills, micro skills - and asks each group for their inputs coupled with an open discussion.

Session 7 Practicing Counselling Skills

Learning Objectives

At the end of the session participants will

- be able to demonstrate use of counselling skills
- learn to evaluate a counselling session



Time 2 hours

Resources

Situations for role plays, checklist for observing quality of counselling session (Handout 6.7) protocol for contraception counselling (Handout 6.8)

Methodology

1. Participants are divided into 3 groups
2. Each group is asked to perform a role-play on the following situations
 - A man wanting his wife to get sterilised after two children
 - Unmarried girl coming for an MTP
 - Women wanting to change the method of contraception from oral pills to Copper-T
3. The groups are given protocols on contraception counselling so that they cover all the relevant aspects in the role-play
4. The groups perform the role-play demonstrating use of various counselling skills.
5. Feedback is obtained from the larger group on the skills and content of the role-play using Handout 6.7
6. Facilitator summarises

Session 8: Woman Centred Counselling

- Objectives**
- Participants will be able to describe characteristics, process and outcome of WCC

Resources OHTs showing characteristics, process and outcome of WCC (OHT 6.10)

Time 1 hour

Methodology

Brainstorming, Presentation through OHTs

- Facilitator asks participants to brainstorm on what they think is meant by WCC and notes down their responses in three columns on the black board. (the columns are not given headings although the facilitator categorises responses according to characteristics, process and outcome. Facilitator relates his/her OHT presentation to the responses listed on the blackboard.
- Facilitator ends the session by emphasising that in subsequent modules on counselling for Gynaecological Problems, Sexuality, Gender-based Violence and Adolescent Health issues, the participants should be conscious of principles of WCC.

Session 9: Conducive Counselling Environment

The counsellor should make the environment such that privacy and confidentiality during the sessions can be maintained, so that the client can talk freely without being interrupted and overheard by anyone.

Learning Objectives

At the end of the session the participants will be able to

- describe a good counselling environment. to maintain privacy and confidentiality during counselling session.

Time 45 minutes to 1 hour

Resource

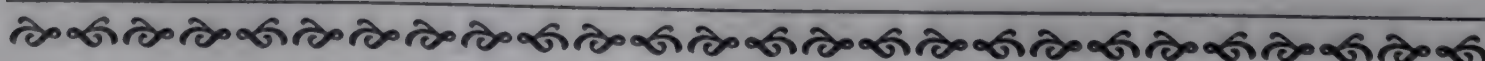
Flip Chart, Pens and pads to note down various settings in which counselling takes place.

Methodology

1. Divide the participants into 3-4 small groups.
2. Let them discuss various locations and settings where counselling can take place.
3. Let the groups note down elements, which can be obstacles for counselling.
4. Let the group reconvene again.
5. Allow them to share the various locations and settings for counselling.
6. Let participants focus on the negative elements in the counselling environment.
7. After sharing and discussion let participants learn the importance of maintaining privacy and confidentiality in a counselling session.

Points to Emphasise

- It may not be possible to have an ideal counselling environment in an OPD situation
- One can talk softly to create verbal privacy in a crowded OPD
- In a small room or where separate room is not available, visual privacy can be created by putting a curtain
- In a home visit situation, client could be taken away nearby if possible, or could be asked to come to health centre



References for Communication

1. **Correlates of provider behaviour : a meta analysis**,—Hall J. Roter D. Katzrl, 1988, Medical Care 26,
2. **Training Manual for Auxilliary Nurse Midwives in Communication and Research into Women's Sexual Health Issues**. *India*. BMC. Published by the Public Health Department of BMC, 1995.
4. **KAB Practices related to HIV/AIDS in four locales of Maharashtra**, Chitale V. and Das S., 1992, TISS).

References for Counselling

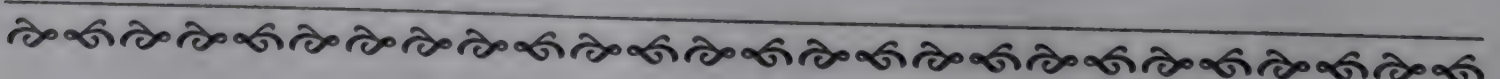
1. **Counselling Skills Training**, D. K. Chaturvedi, PVT. Ltd., New Delhi.
2. **Training Manual of Auxiliary Nurse-Midwives in Communication and Research**
3. **Training Resource (1992)**, College of Nursing, University of PPE, England.

Reference from Internet Sites

<http://www.google.com>

HANDOUT 6.1**Statements**

1. Unmarried people should not have access to contraception methods.
2. HIV positive people have sex with multiple partners.
3. It is all right to insist that poor families adopt family planning as they cannot afford large families.
4. Daughters should not be given freedom.
5. It is all right for boys to have sex before marriage.
6. Clients do not comply with treatment because they do not value doctor's advice.
7. Homosexuality is wrong.
8. Girls do not masturbate.
9. Sex workers are responsible for spreading HIV.
10. Girls should choose caring professions like teaching and nursing.
11. Public health system should make special provision for caring for unwed mothers.



HANDOUT 6.2

OBSERVATION CHECKLIST FOR MONITORING ONE-TO-ONE HEALTH EDUCATION SESSION

1 Introduction

- 1.2 Did the counsellor introduce herself/himself?
- 1.3 Did the counsellor explain what was the purpose of the session?

2 Gathering relevant facts/ information

- 2.1 Did the counsellor encourage the client to share her perceptions, ideas, concepts?
- 2.2 Did the counsellor try to understand the client's concepts/ ideas/ perceptions?
- 2.3 Did the counsellor listen to the client's ideas, concepts, perceptions patiently?
- 2.4 Did the counsellor ridicule the client about "wrong" beliefs?

3 Giving information

- 3.1 Did the counsellor use IEC material to give information?
- 3.2 Was the material used suitable?
- 3.3 If no, what other material could have been used?
- 3.4 Was all relevant information that would enable decision-making given?

4 Quality of information

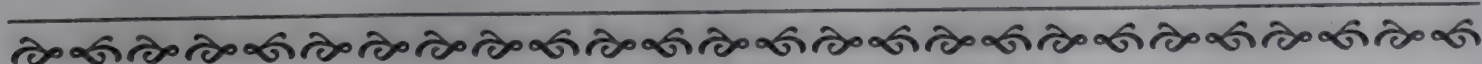
- 4.1 Was all the information given ?
- 4.2 If not, what information was left out?
- 4.3 Was the information accurate?
- 4.4 If not, what was wrong?

5 Answering queries

- 5.1 Did the counsellor answer the questions asked by the client?
- 5.2 Did the counsellor ask the client if s/he had any questions?
- 5.3 Did the counsellor repeat the explanation patiently if the client did not understand ?
- 5.4 Did the counsellor tell the client that she does not know the correct answer in case she/he is not sure or in doubt?

6 Language

- 6.1 Did the counsellor/facilitator use simple, easy to understand language?
- 6.2 Did the counsellor try to use local/colloquial terms for medical terms?
- 6.3 Did the counsellor use difficult words?
- 6.4 Did the counsellor use medical/technical words?
- 6.5 Did the counsellor use English words?



6.6 If medical or English words were used, did the counsellor try to find out whether the client understood the words?

6.7 Was the information organised and in logical order?

7 Ensuring that client understood the information

7.1 Did the counsellor ensure that the client understood the information given to her/him?

7.2 At the end of the session, did the counsellor summarise the issues discussed?

8 Time to absorb the information

8.1 Was the information given hurriedly?

8.2 Did the counsellor allow the client some time to think about her decision?

9 Was the interaction two-way ?

HANDOUT 6.3

SWOT ANALYSIS

- 1) I am good at _____
- 2) Because I am a girl / boy _____
- 3) The best thing that I like about myself _____
- 4) The thing that I hate about myself _____
- 5) I feel that I can not _____
- 6) I feel that I can not do it, but I could do it if _____
- 7) I feel very insecure when _____
- 8) I feel very secure when _____
- 9) I can talk freely about _____
- 10) I feel shy about _____
- 11) I could have achieved something if _____

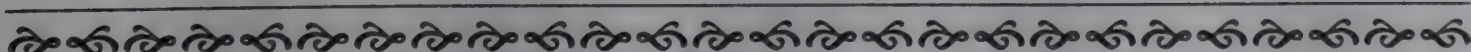
Key-

1,2,3,8 denotes your **Strength**

2,4,5,10 denotes your **Weakness**

6,9,11 denotes your **Opportunity**

7 denotes your **Threat**



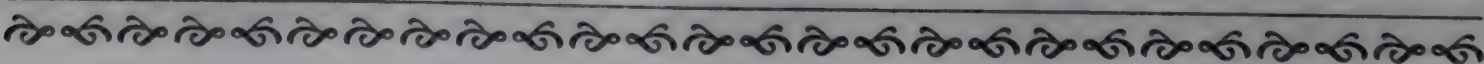
HANDOUT 6.4

SELF-AWARENESS QUESTIONNAIRE

Mark yourself on 100 for each question e.g. 50/100

Marks out of 100

- 1. Self-acceptance (I like myself) _____
- 2. Ability and presence of mind to speak the right thing _____
- 3. Ability to express myself _____
- 4. Competence on the job _____
- 5. Enjoying meeting people _____
- 6. Competence in managing my time _____
- 7. Enjoying doing the work _____
- 8. Engaged in continual self-development _____
- 9. Knowing what is good for me and can assert myself _____
- 10. Remaining always cheerful _____
- 11. Enjoying being close to nature _____
- 12. Ability to create trust in others _____
- 13. Capacity to earn money _____
- 14. Capacity to imagine new possibilities and alternatives _____
- 15. Courage to change and form new habits _____
- 16. Self-reliance _____
- 17. Maintaining a healthy family relationship _____
- 18. Controlling my behaviour _____
- 19. Being in touch with my feelings _____
- 20. Self- confidence _____
- 21. Capacity to relax _____



HANDOUT 6.5

QUESTIONNAIRE ON PERSONAL EFFECTIVENESS

Instructions

Please read each of the statements given below and indicate how much the statement is true of your behaviour, by rating as follows:

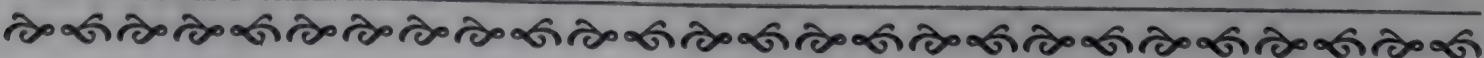
- 4: Most characteristic of you, or, you always seem to be doing this
- 3: Fairly true of you, or, you seem to be doing this quite often
- 2: Somewhat characteristic of you
- 1: Not characteristic of you, or you do this only sometimes
- 0: Not at all characteristic of you, or you seldom do this

Statements

- 1. I find it difficult to be frank with people unless I know them very well _____
- 2. Generally, I hesitate to express my feelings to others _____
- 3. I'm quiet, quick and strong in expressing my opinions in a group or to a person even if this may be unacceptable to them _____
- 4. When someone discusses his problems I do not spontaneously share my experiences and personal problems of a similar kind with him. _____
- 5. I enjoy talking with others about my personal concerns and matters _____
- 6. I listen carefully to others' opinion about my behaviour _____
- 7. When someone directly tells me how he feels about my behaviour, I tend to close up and stop listening _____
- 8. I take steps to find how my behaviour has been perceived by the person with whom I have been interacting _____
- 9. If someone criticises me, I hear him at that time but do not bother myself about it later _____
- 10. I value what people have to say about my style, behaviour etc. _____
- 11. I tend to say things that turn out to be out of place _____
- 12. In hindsight I regret saying something tactlessly. I like to check how a person will react to what I'm going to tell him and accordingly communicate with him _____
- 13. Most often, I pick up cues about other's feelings and reactions, even when I'm involved in arguments or conversation _____
- 14. I'm often surprised to discover (or be told) that people were put off or bored or annoyed, when I thought they were enjoying interacting with me. _____

SCORING SHEET

QUESTIONS	YOUR SCORE	REVERSAL	ACTUAL SCORE
No. 1	_____	YES	_____
No. 2	_____	YES	_____
No. 3	_____	NO	_____
No. 4	_____	YES	_____
No. 5	_____	NO	_____
TOTAL SCORE FOR SELF DISCLOSURE (NO.s 1 TO 5)			_____
No. 6	_____	NO	_____
No. 7	_____	YES	_____
No. 8	_____	NO	_____
No. 9	_____	YES	_____
No. 10	_____	NO	_____
TOTAL SCORE FOR FEEDBACK (NO.s 6 TO 10)			_____
No. 11	_____	YES	_____
No. 12	_____	YES	_____
No. 13	_____	NO	_____
No. 14	_____	NO	_____
TOTAL SCORE FOR SENSITIVITY (NO.s 11 TO 15)			_____



HANDOUT 6.6

THE JOHARI WINDOW

Figure 1

	Known to self	Not known to self
Known to others	Quadrant 1 Area of Free Activity (on top of table)	Quadrant 2 Blind area
Not known to others	Quadrant 3 Avoided or hidden area (under the table)	Quadrant 4 Area of unknown activity

A better way of understanding the relationship between people

The concept of the Johari Window seems to be one excellent way of graphically visualizing the relationship between individuals. It is simply a window with four quadrants. The four quadrants represent the whole person in relation to others.

QUADRANT 1: is the behaviour and motivation which is known to self and others. It shows the extent to which two or more persons can give freely and take; work together, and enjoy experiences together. The larger this area, the greater is the person's contact with reality, and more available are his abilities and needs to himself and his associates. This can also be labelled the quadrant of openness, honesty and frankness but not naivete.

QUADRANT 2: The Blind area represents behaviour and motivations which are not known to one's self but which are readily apparent e.g. speech and gestures of which the person himself is unaware but which is quite obvious to others. This can be in the form of a facial twitch. Or an individual may have an excessive tendency to dominate, which may be perfectly obvious to everyone but not in the least obvious to the man who is doing the domination. Most people's Quadrant 2 is larger than they think. This is particularly evident in group or committee situations where the individual's behaviour is under the scrutiny of many people.

QUADRANT 3: is behaviour and motivation which is open to the self but hidden from other people. This quadrant is sometimes referred to as the Hidden Agenda. For example, a man may want to

get a particular assignment from the boss in order to make himself look good as a result of carrying out that assignment, but does not tell the boss what he wants nor does he go about getting the assignment in an obvious way.

Another example is the person who knows well that he resents a remark made by an individual in a meeting, but he keeps the resentment to himself. Or in a committee meeting a member may focus attention on a particular project which he knows is embarrassing to one of the other members.

A convenient way of differentiation between Quadrant 1 and 3 is to think of Quadrant 1 as those things which are on TOP OF THE TABLE and Quadrant 3 as those behaviours which are motivated by issues UNDER THE TABLE.

QUADRANT 4: is the area of activity where behaviour and motivation are unknown to the individual or to others. We know this quadrant exists because both the individual and persons with whom he is associated discover from time to time new behaviour or new motives which were really there all along. An individual may surprise himself and others, for example, by taking over the group's direction during a critical period; or another person may discover that he has great ability to bring two warring factions together. He never saw himself as the peacemaker before, nor did anyone else, but the fact is that the potential for this sort of activity and the actual behaviour was there all the time.

Figure 2

	Known to self	Not known to self
Known to others	I Free Activity	II Blind area
Not known to others	III Hidden	IV

Figure 2. Illustrates how a person looks when he is in a completely new situation or when he meets a person for the first time. The area of open shared activity represented in Quadrant 1 is very small. People tend to behave in a relatively superficial manner. Social convention provides a pattern of getting acquainted and it is considered bad form to act too friendly too soon or to reveal too much. This same constricted picture may be typical of some persons who have difficulty in relating to other persons. An overly shy person may, for example, have difficulty in developing a large Quadrant 1 even after much time with a group, or another individual, has elapsed. Sometimes an individual may hide behind a flurry of words, but very little of him becomes known or available to others.

Figure 3

	Known to self	Not known to self
Known to others	OPEN	BLIND
Not known to others	HIDDEN	UNKNOWN

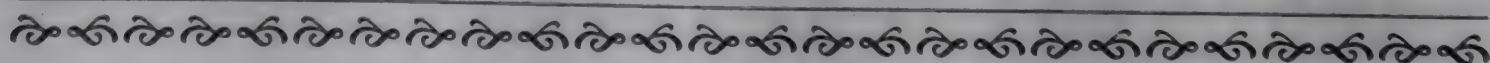
Figure 3. It takes energy or psychological resources to wall off Quadrant 2, 3 and 4. The larger the first quadrant the closer to self realization is the individual, in the sense that he is meeting his needs, utilising his abilities and interests at the same time that he is making them available to others. It would be a mistake, however, to think of a large quadrant 1 as mere extroversion, gregariousness and sociability. Rather the emphasis is on personal freedom and capability of working with others, and enjoying experiences with others according to one's needs and work requirements. The attitude of persons to the individual illustrated in figure 2 is often that of suspicion and distrust. On the other hand, attitude towards persons represented in figure 3 is often that of acceptance and understanding.

Whether the relationship is between that of associates, superior and subordinate, or between divisions of the company or departments, the relationships which conform to figure 3 result in greater understanding, co-operation and freedom of activity. It has also been demonstrated to result in more creativity, higher work output as well as individual and organisation growth. Relationships which follow figure 2 pattern are characterised by suspicion, distrust, tension, anxiety and backbiting. This results in lower work output and thwarts individual as well as organisational growth. The fact is that individuals who are used to operating on a small Quadrant 1 basis find it very painful, at least initially to enlarge Quadrant 1. However, the enlargement of Quadrant 1 does result in a better and more productive relationship. This can be illustrated by the cohesive bond of those who have been through a crisis together. Under great tension and stress we tend to reveal more of ourselves to those who are experiencing the same stress and tension.

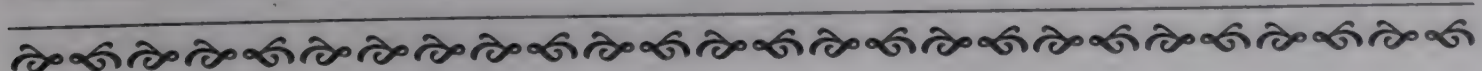
HANDOUT 6.7

CHECKLIST FOR ASSESSING QUALITY OF COUNSELLING

1.	Did the counsellor ask the client to take a seat? Was the client seated?	1. Yes	2. No	3. Not applicable	4. Do not know
2.	Did the counsellor explain what the client should expect from the session?	1. Yes	2. No	3. Not applicable	4. Do not know
3.	Did the counsellor assure the client that the discussion would be kept confidential and not shared with anyone else?	1. Yes	2. No	3. Not applicable	4. Do not know
4.	Was the accompanying person politely asked to wait outside if privacy was required?	1. Yes	2. No	3. Not applicable	4. Do not know
5.	Did the counsellor enquire about client's past illnesses/treatment/investigations?	1. Yes	2. No	3. Not applicable	4. Do not know
6.	Did the counsellor listen to the client without interrupting her/him?	1. Yes	2. No	3. Not applicable	4. Do not know
7.	Did the counsellor listen attentively to the client?	1. Yes	2. No	3. Not applicable	4. Do not know
8.	Did the counsellor ensure that s/he understood correctly what the client had to say?	1. Yes	2. No	3. Not applicable	4. Do not know
9.	Did the counsellor paraphrase what client had said?	1. Yes	2. No	3. Not applicable	4. Do not know
10.	In case of discrepancies in the client's narrative, did the counsellor clarify them with the client?	1. Yes	2. No	3. Not applicable	4. Do not know
11.	Did the counsellor answer the questions asked by the client?	1. Yes	2. No	3. Not applicable	4. Do not know
12.	Did the counsellor ask the client if s/he had any questions?	1. Yes	2. No	3. Not applicable	4. Do not know
13.	Did the client ask any questions?	1. Yes	2. No	3. Not applicable	4. Do not know
14.	Did the client ask any questions related to sexual relations?	1. Yes	2. No	3. Not applicable	4. Do not know
15.	Did the counsellor answer questions asked by the client regarding sexual relations?	1. Yes	2. No	3. Not applicable	4. Do not know
16.	Did the counsellor give information regarding investigations prescribed, reason for doing the investigations, where to get them done, and the costs involved?	1. Yes	2. No	3. Not applicable	4. Do not know



17.	Did the counsellor give information regarding surgery/ procedure advised, the reason for it, where to get it done and what it would cost, and the procedure followed during surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
18.	Did the counsellor instruct the client about how to prepare for the surgery/procedure?	1. Yes	2. No	3. Not applicable	4. Do not know
19.	Did the counsellor explain the admission procedure to the client?	1. Yes	2. No	3. Not applicable	4. Do not know
20.	Did the counsellor ensure that the client understood the information given to her/him?	1. Yes	2. No	3. Not applicable	4. Do not know
21.	Was the client asked to repeat the instructions?	1. Yes	2. No	3. Not applicable	4. Do not know
22.	Did the counsellor encourage client to speak?	1. Yes	2. No	3. Not applicable	4. Do not know
23.	Did the counsellor ask the client to say what s/he thought/knew about the situation/condition before giving information?	1. Yes	2. No	3. Not applicable	4. Do not know
24.	Did the counsellor ask open questions? Did the counsellor probe where required?	1. Yes	2. No	3. Not applicable	4. Do not know
25.	Did the counsellor modulate her/his voice while speaking to the client?	1. Yes	2. No	3. Not applicable	4. Do not know
26.	Did the counsellor use technical words while giving information?	1. Yes	2. No	3. Not applicable	4. Do not know
27.	Were the counsellor's expressions responsive to the emotions expressed by the client?	1. Yes	2. No	3. Not applicable	4. Do not know
28.	Did the counsellor pause at appropriate times during the counselling session?	1. Yes	2. No	3. Not applicable	4. Do not know
29.	Did the counsellor reassure the client?	1. Yes	2. No	3. Not applicable	4. Do not know
30.	Did the counsellor help the client focus on the important issues at hand?	1. Yes	2. No	3. Not applicable	4. Do not know
31.	Did the counsellor listen to the client without being critical or judgmental?	1. Yes	2. No	3. Not applicable	4. Do not know
32.	Did the counsellor use IEC material to give information?	1. Yes	2. No	3. Not applicable	4. Do not know
33.	At the end of the session, did the counsellor summarise the issues discussed?	1. Yes	2. No	3. Not applicable	4. Do not know
34.	Did the counsellor tell the client about follow-up: whether required, when, etc.?	1. Yes	2. No	3. Not applicable	4. Do not know
35.	Did the counsellor smile (if appropriate) at the end of the session?	1. Yes	2. No	3. Not applicable	4. Do not know



HANDOUT 6.8

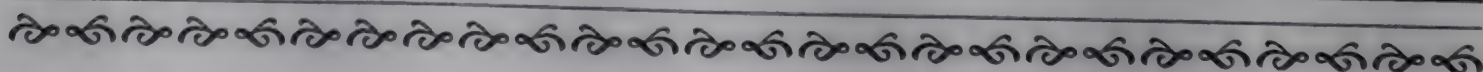
PROTOCOL FOR MTP AND CONTRACEPTION COUNSELLING

Name of the observer : _____ Client number : _____

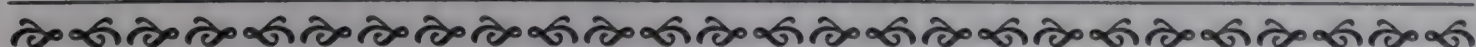
Date : _____ Time : _____

For each question, please circle the appropriate option

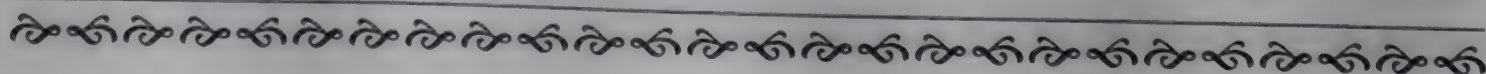
1	Did the counsellor ask the date of the last menstrual period?	1. Yes	2. No	3. Not applicable	4. Do not know
2	Did the counsellor take the history of number of children, pregnancies, abortions/MTPs?	1. Yes	2. No	3. Not applicable	4. Do not know
3	Did the counsellor discuss in detail the reasons for aborting present pregnancy?	1. Yes	2. No	3. Not applicable	4. Do not know
4	Did the counsellor ask if client's husband has accompanied her?	1. Yes	2. No	3. Not applicable	4. Do not know
4.1	Did the counsellor ask the client if she would like to invite the husband inside?	1. Yes	2. No	3. Not applicable	4. Do not know
4.2	Did the counsellor ask the husband to come inside if the client so wished ?	1. Yes	2. No	3. Not applicable	4. Do not know
5	Did the counsellor ask the client if she knew how MTP was done?	1. Yes	2. No	3. Not applicable	4. Do not know
5.1	If the client knew about the methods of MTP, did the counsellor ask her to share the information?	1. Yes	2. No	3. Not applicable	4. Do not know
5.2	If client did not have complete information, did the counsellor explain how MTP is done?	1. Yes	2. No	3. Not applicable	4. Do not know
6	After she gave this information, did the counsellor ask the client if she wanted an MTP?	1. Yes	2. No	3. Not applicable	4. Do not know
7	Did the counsellor then explain the risks associated with MTP?	1. Yes	2. No	3. Not applicable	4. Do not know
8	Did the counsellor allow the client some time to think about her decision?	1. Yes	2. No	3. Not applicable	4. Do not know
8.1	Did the counsellor ask the client if she wanted to go out of the centre to think and make a decision?	1. Yes	2. No	3. Not applicable	4. Do not know
9	Did the counsellor ask the client if she still wanted to have an MTP after she had reviewed all the information given to her?	1. Yes	2. No	3. Not applicable	4. Do not know
10.	Did the counsellor inform the client that at times MTP results in incomplete evacuation of the contents of the uterus?	1. Yes	2. No	3. Not applicable	4. Do not know



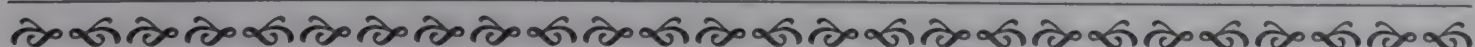
11.	Did the counsellor ask the client about her plans to prevent a pregnancy immediately after the MTP? Did the counsellor ask if the client knew of spacing methods?	1. Yes	2. No	3. Not applicable	4. Do not know
12.	Did the counsellor ask the client if she knew about the process of conception?	1. Yes	2. No	3. Not applicable	4. Do not know
12.1	If the client did not know this, did the counsellor give her the relevant information?	1. Yes	2. No	3. Not applicable	4. Do not know
13.	Did the counsellor ask if the client had used any contraceptive/spacing method in the past?	1. Yes	2. No	3. Not applicable	4. Do not know
13.1	If the client had used some method, did the counsellor encourage her to discuss it?	1. Yes	2. No	3. Not applicable	4. Do not know
14.	If the client did not know about contraceptives, did the counsellor ask if she wanted more children?	1. Yes	2. No	3. Not applicable	4. Do not know
15.	If client wanted more children, did the counsellor give information about reversible/temporary contraceptives as per the checklist given below?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1	Oral Contraceptive Pills (OCP)				
15.1.1	Did the counsellor ask the client what she knew about OCPs or what she has heard about OCPs?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1.2	Did the counsellor address misconceptions if any?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1.3	Did the counsellor explain the function of OCPs?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1.4	Did the counsellor explain the benefits of OCPs?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1.5	Did the counsellor explain the side effects of OCPs?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1.6	Did the counsellor explain who can use OCPs and who cannot?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1.7	Did the counsellor explain how to use OCPs, at least briefly?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2	Condom				
15.2.1	Did the counsellor ask the client what she knew about condoms or what she has heard about condoms?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.2	Did the counsellor address misconceptions if any?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.3	Did the counsellor discuss who should use the condom and when?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.4	Did the counsellor explain how the condom functions as a contraceptive?	1. Yes	2. No	3. Not applicable	4. Do not know



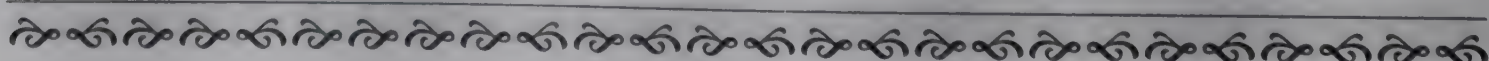
15.2.5	Did the counsellor explain the advantages of using condom?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.6	Did the counsellor explain the disadvantages of condom use?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.7	Did the counsellor explain how to use a condom? (If male partner had accompanied the client, was he called inside and explained about condom use?)	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.8	Did the counsellor demonstrate how to use condom?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3	Copper T (CuT)				
15.3.1	Did the counsellor ask the client what she knew or had heard about CuT?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.2	Did the counsellor address misconceptions if any?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.3	Did the counsellor explain how the CuT functions as a contraceptive?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.4	Did the counsellor tell the client when the CuT should be inserted?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.5	Did the counsellor explain the advantages of CuT?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.6	Did the counsellor discuss the disadvantages of CuT?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.7	Did the counsellor discuss which women should, and which women should not, use CuT?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.8	Did the counsellor ask if the client had any symptoms of RTI?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.9	If the client reported symptoms of RTI, did the counsellor advise her not to insert CuT immediately and discuss about intercourse?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.10	Did the counsellor demonstrate how the CuT is inserted?	1. Yes	2. No	3. Not applicable	4. Do not know
16.	If the client did not want more children after MTP, did the counsellor give her information on permanent methods of contraception as per the checklist given below?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1	Female Sterilisation				
16.1.1	Did the counsellor ask the client if she knew or had heard anything about female sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.2	Did the counsellor address misconceptions if any?	1. Yes	2. No	3. Not applicable	4. Do not know



16.1.3	Did the counsellor tell the client that this is a permanent method and the woman will not be able to conceive after this?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.4	Did the counsellor explain reasons for inability to conceive after sterilisation ?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.5	Did the counsellor tell the client when this surgery should be performed?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.6	Did the counsellor discuss the advantages of female sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.7	Did the counsellor discuss the disadvantages of such sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.8	Did the counsellor inform the woman about the required length of stay at the hospital following surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.9	Did the counsellor tell the client about the duration of rest required to be taken after sterilisation surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.10	Did the counsellor explain the surgical procedure?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.11	Did the counsellor tell the client where to go for the surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.12	Did the counsellor discuss the possibility of failure of the surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2	Male sterilisation				
16.2.1	Did the counsellor ask the client if she knew or had heard anything about male sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.2	Did the counsellor address misconceptions if any?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.3	Did the counsellor explain that this is a permanent method and the woman will not be able to conceive after this?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.4	Did the counsellor explain the reasons for inability to conceive after the operation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.5	Did the counsellor discuss the advantages of male sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.6	Did the counsellor discuss disadvantages of male sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.7	Did the counsellor tell the client about the required length of stay in the hospital after the surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.8	Did the counsellor say anything about the number of days that the man will be required to rest after sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know



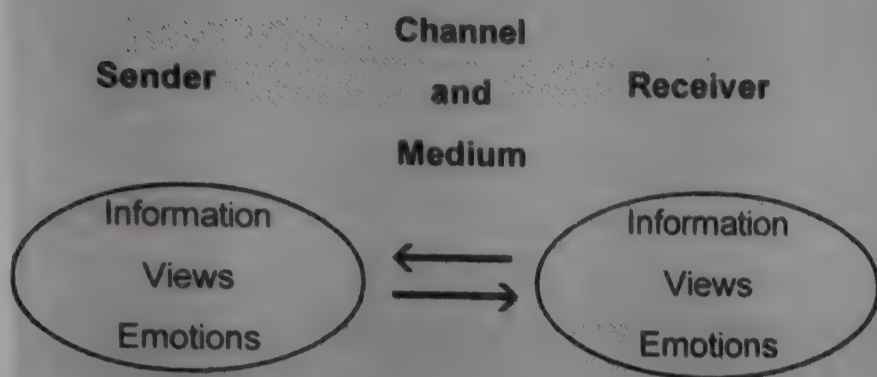
16.2.9	Did the counsellor explain about when this surgery should be performed?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.10	Did the counsellor explain surgical procedure?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.11	Did the counsellor discuss the possibility of failure of the surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
17.	Did the counsellor ask the client which of the aforementioned methods she wanted to adopt?	1. Yes	2. No	3. Not applicable	4. Do not know
18.	If the client made a decision, did the counsellor explain that it was important to inform the client's husband of this decision?	1. Yes	2. No	3. Not applicable	4. Do not know
18.1	If the client agreed, did the counsellor give all the information to the client's husband?	1. Yes	2. No	3. Not applicable	4. Do not know
18.2	Did the counsellor start the discussion with male sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
18.3	Did the counsellor inform the client and her husband about temporary methods?	1. Yes	2. No	3. Not applicable	4. Do not know
18.4	Did the counsellor inform the client and her husband about permanent methods?	1. Yes	2. No	3. Not applicable	4. Do not know
19.	Did the counsellor ask the husband which method they (the couple) would prefer?	1. Yes	2. No	3. Not applicable	4. Do not know
19.1	Did the counsellor ask the husband's opinion on the method preferred by the client?	1. Yes	2. No	3. Not applicable	4. Do not know
20.	Did the counsellor allow them time to think before making a decision?	1. Yes	2. No	3. Not applicable	4. Do not know
21.	Did the counsellor repeat the information for the method selected by the couple?	1. Yes	2. No	3. Not applicable	4. Do not know
21.1	If required, did the counsellor give detailed information about the method selected by the couple?	1. Yes	2. No	3. Not applicable	4. Do not know
21.2	Did the counsellor give the client/husband the date and time for admission?	1. Yes	2. No	3. Not applicable	4. Do not know
22.	If no decision was taken, did the counsellor fix another appointment?	1. Yes	2. No	3. Not applicable	4. Do not know
23.	Did the counsellor tell the client that she could refer other women to the counselling centre for information on contraception and other reproductive conditions?	1. Yes	2. No	3. Not applicable	4. Do not know
24.	Did the counsellor smile at the end of the session?	1. Yes	2. No	3. Not applicable	4. Do not know



OVER-HEAD TRANSPERENCIES

OHT 6.1

TWO WAY COMMUNICATION



Interpersonal communication is face to face, verbal and non verbal exchange of information, feelings, between two or more people.

OHT 6.2

NON-VERBAL AND VERBAL COMMUNICATION SKILLS

Non-verbal Communication Skills

- Eye contact
- Facial Expression
- Body language
- Physical distance between the counsellor and the client
- Active listening and observation
- Appropriate use of smile

Verbal Communication Skills

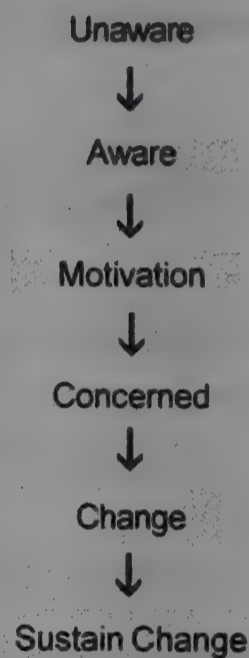
- Allowing the client to complete the sentence without interrupting
- Use of encouragers
- Use of voice
- Quality of information given to the client

OHT 6.3

PROCESS OF BEHAVIOURAL CHANGE

"A study revealed that 10% of the truck drivers knew about use of condoms. However only 1% of them actually used condoms."

Source: TISS Study



The process of behavioural change

OHT 6.4

EFFECT OF TONE AND EMPHASIS ON WORDS

"Maro, mat chhodo!"

("Kill, do not forgive!")

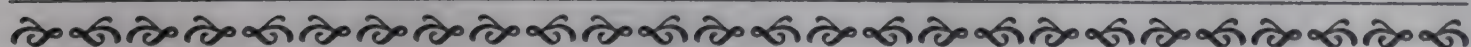
"Maro mat, chhodo!"

("Kill not, forgive!")

"Woman without her man is nothing"

"Woman: without her, man is nothing".

"Kam se kam chot lage!"



OHT 6.5

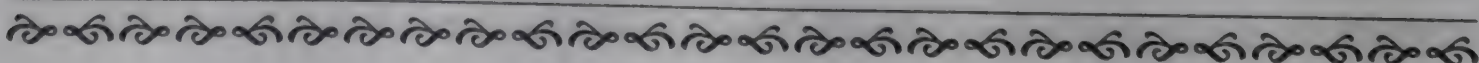
PRINCIPLES OF COMMUNICATION FOR BEHAVIOURAL CHANGE

- Mere information and awareness does not lead to behavioural change
- Prejudices and biases about a person or group of people affects our behaviour with them. It could be a barrier to change
- It is difficult to change people overnight. Changing perceptions and attitudes is not easy and is a long process
- It is important to present technical knowledge in an organized and logical manner for better recall from the clients
- Emphasis on certain words in communication changes their meaning. It is important to pause and emphasise certain words to convey the right meaning

OHT 6.6

USING APPROPRIATE MEDIA

You remember 20% of what you hear	You remember 40% of what you see	You remember 80% of what you hear and see	You remember 90% of what you hear, see and do
1. Conversations	1. Posters	1. Video	1. Demonstration
2. Dialogues	2. Leaflets	2. Cinema	2. Role Play
3. Lectures	3. Pamphlets	3. Flash cards	3. Games and exercises
4. Debates/ Discussions	4. Books	4. Stories based on Flanellogram	
5. Story telling	5. Exhibitions	5. Puppet shows	
		6. Street plays	



OHT 6.7

THE JOHARI WINDOW

Figure 1

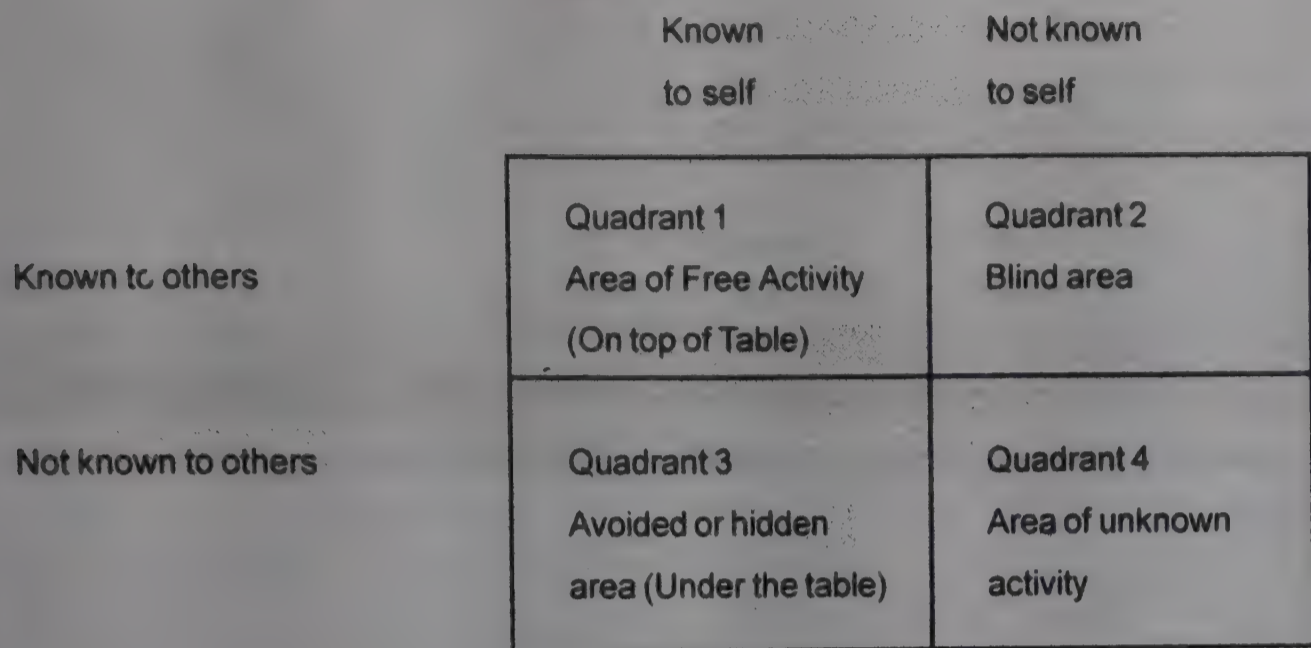


Figure 2

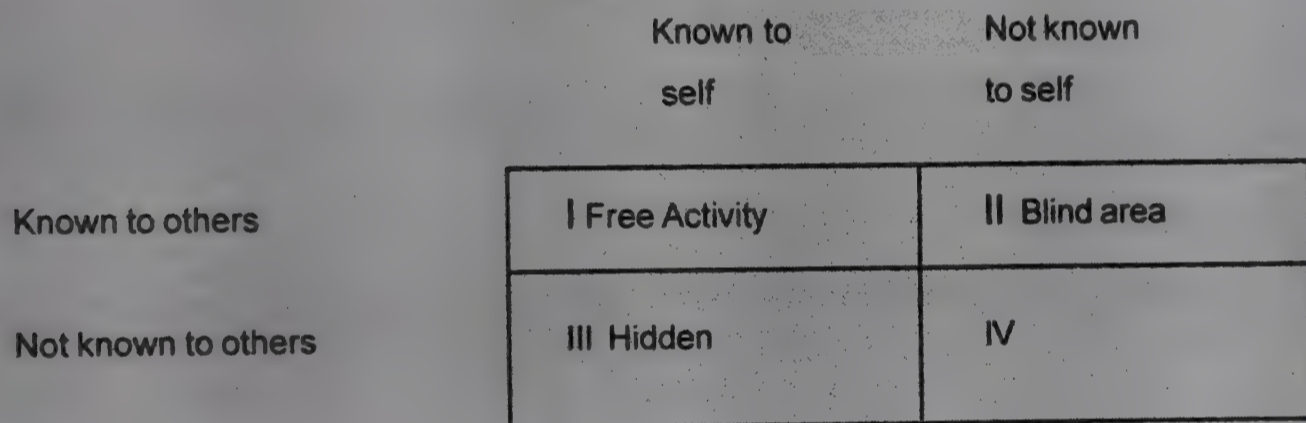
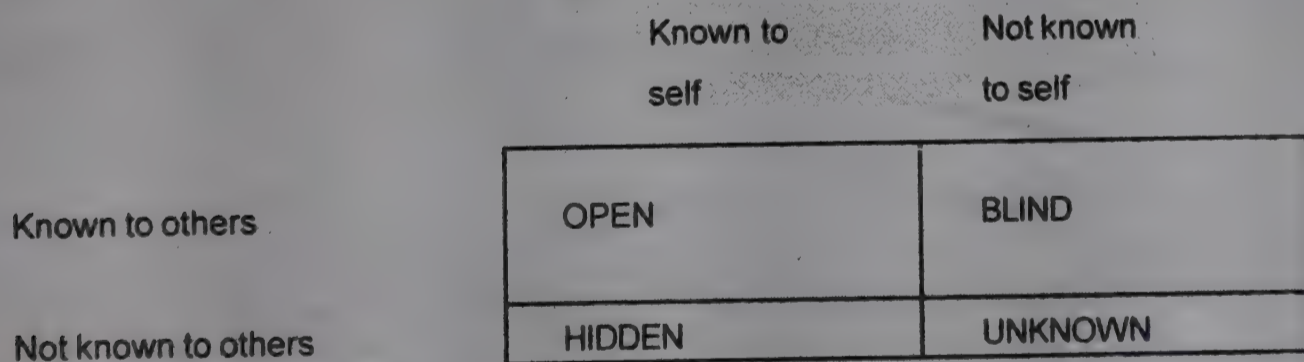


Figure 3



OHT 6.8

ERRORS IN COUNSELLING

- Directing
- Labelling
- Moralising, Preaching
- Giving false reassurance
- Denying client's feelings
- Encouraging dependence
- Breaking confidentiality
- Interrogating

OHT 6.9

MICRO AND MACRO SKILLS

Micro Skills

- **Clarification**

Use questions such as "Did you say _____?", "According to you _____?", "Was it -", to ensure that the counsellor has understood the client's message correctly

- **Asking open-ended and probing questions**

"Could you tell me in detail what happened?", "Could you elaborate?" encourage clients to share more information.

- **Empathy**

Ability to see and feel the world from the perspective of another person while remaining objective.

- **Reassurance**

Reassure the client by saying "Don't lose hope" or "Don't worry, things will change for the better" or "Have faith, things should be fine"

- **Summarising**

Ensure that the counsellor has understood correctly. List all the important and main points of the discussion.

- **Recapitulating**

To find out if the information has been understood by the client. To gauge if the client is attentively listening to the information.

Macro Skills

- **Paraphrasing of content**

Client : I know I shouldn't be so hard on myself. But I can't seem to stop blaming myself ..
Counsellor : You are aware that being critical of yourself isn't helpful, even though you haven't found a way to give it up

- **Reflection of Feeling**

Client : I feel very agitated about how my husband is treating me and I really don't know how to change him.
Counsellor : You seem to be very angry with your husband because of his behaviour. You also seem to be worried about him.

- **Appropriate use of silence**

Client : How could this happen to me? What have I done to deserve this? (begins to cry) (looking down)
Counsellor : (softly after 10 to 15 seconds) Would you like to talk about this?

- **Focusing**

Client : I went to my native place and my uncle died. He was very fond of my daughter. He left his land in my daughter's name. So I was busy getting the paper work done. I am going again next month. We have a big house in the gaon.
Counsellor : Okay, now, shall we come back to your daughter's health? I think you want to discuss that.

- **Confrontation**

Client : No one in my office likes me, there's no one I can talk to...
Counsellor : Now that's an exaggeration, surely.....

WHAT IS WOMAN CENTRED COUNSELLING?

Values and Ethics in Woman Centred Counselling

Woman Centred Counselling

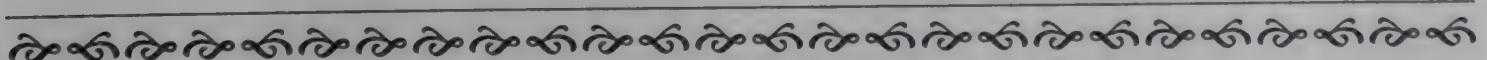
- believes that women's problems are not a result of personal inadequacies, but created by unjust and oppressive social structures.
- does not encourage women to adjust to their situation, women are challenged to become aware of their rights.
- advocates changes in society's institutions and structures to allow equal treatment and opportunity for both men and women. Change has to take place in all the units of the society. Involving the community is an important aspect.
- is combined with improving self-esteem, challenging personal internalised values and gender identities towards a process of self-realisation and self-discovery.
- challenges male expectations which are based on traditional role models and stereotypes of women by introducing counterculture and different ways of looking at these stereotypes.
- gives value to the woman's own self (her way of thinking and analysis, feelings) which reveals the inner resources that she possesses.
- assumes women's right to self-determination and control over their own lives.
- asserts every woman's right to be an active participant in her own healing, where she makes her own decisions.
- validates a woman's right to her feelings, decisions and intelligence - and also validates her experiences.

The process of woman centred counselling

- challenges the subordinate status of the woman in her family and inspires confidence. (Usually women have the experience of being silenced by their families.)
- helps the woman to break her oppressive support system in life-threatening situations.
- helps women to identify negative responses that break communication and gives practical suggestions to improve their communication.

Results of woman centred counselling

- Attempts conscientisation of women to oppose oppression in their daily lives and to dialogue around their own women's issues.
- The women, whose perception of their individuality is raised, start asking questions about being battered and realise that they need not have suffered so.
- Information regarding the support system is also shared. These activities make women active participants, they form groups and act as pressure groups and help other women in the community.
- This facilitates women to overcome isolation and also to relocate themselves in different relationships, besides the family and community relationships.
- WCC increases women's vocabulary to define their own experiences. It provides them objectivity about their own lives.
- Women are empowered with knowledge, skills and are also helped in changing their attitude.
- The acquired knowledge helps women review the entire situation and to take informed decisions.



ANNEXURE 6.1

ROLE PLAY FOR NON-VERBAL AND VERBAL SKILLS

Non-verbal Skills

Facilitator explains that 70% of our communication is non-verbal hence its importance. Each of the non-verbal skills are then enacted through short role plays, episodes demonstrating appropriate and inappropriate ways of counsellors behaviour. After each episode facilitator draws attention of the participants, to the bahaviour and feelings of the client in response to the counsellor's appropriate or inappropriate behaviour..

Episode 1 (a) No eye contact

Woman: Madam, I want to *clean my thaili* (I want MTP)

Counsellor: (Does not look-up and starts asking questions and writing on the paper without looking at the patient) What is your name? (patient answers and the counsellor writes down on a form) What is your age? How many children you have? (Patient answers all the questions and counsellor writes them down) Ok tell me what you want ?

Woman: You know what happened actually —(expects counsellor to look up) the condom tore and I thought my period is irregular so —(seeing that the counsellor is not acknowledging the woman feels uncomfortable and dissatisfied and stops talking)

Counsellor: Go on — I am listening (...still looking at the paper)

Woman: So actually madam I want to —— (stops talking and says to herself: 'what is this, I have come to talk about my problem and she is not even listening to me').

Facilitator's Note :

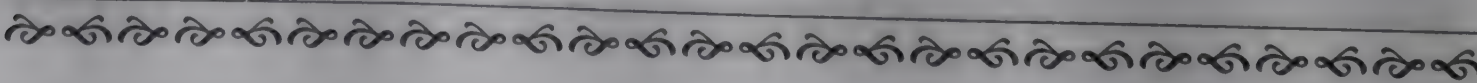
We saw that since the counsellor was not making any eye contact the woman feels discouraged and stops talking. She feels rejected, not listened to which can result in anger or sadness and obstructs communication completely.

Episode 1 (b) Staring at the patient

Above episode is repeated with the counsellor staring at the woman while talking. This makes the woman feel uncomfortable and she starts looking scared and avoids the eye contact.

Episode 1 (c) Proper Eye contact

Same episode is repeated with proper eye contact. Counsellor maintains proper balance between keeping eye contact and writing on the paper. The woman is able to share her problem without hesitation and looks at ease and satisfied by the attention given by the counsellor.



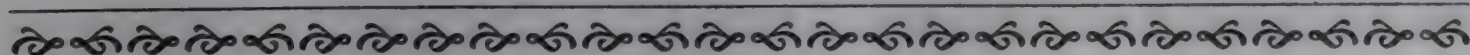
Episode 2 (a) Facial Expression

- Counsellor: Yes, please come in, have a seat - what do you want?
- Woman: You know what - actually I missed my period - and -
- Counsellor: Are you pregnant?
- Woman: Yes, I think so but - this child is - I mean my lover - lover's child, I am not married to him.
- Counsellor: What? (exclaims shockingly) You are not married and pregnant? Lover's child? (the expression is like the woman has done something terrible and she should be ashamed of it).
- Woman: Looks scared and ashamed (says to herself: 'oh! I should not have told her the truth, now I don't know how they are going to treat me').

Episode 2 (b)

Same episode is repeated with the counsellor showing concern and does not show an expression of shock, but tries to ask questions and clarify the situation so that woman could be further guided.

- Woman: You know what - actually I missed my period - and -
- Counsellor: Are you pregnant?
- Woman: Yes, I think so but - this child is - I mean my lover - lover's child, I am not married to him.
- Counsellor: When did you get your last period?
- Woman: Almost 2 months before.
- Counsellor: Ok, has your lover come with you?
- Woman: No, I have come alone.
- Counsellor: Are you thinking of marrying him?
- Woman: No, actually he ditched me and ran away.
- Counsellor: Ok, see first of all we need to check whether you are really pregnant.
- Woman: But I don't want this child, I want MTP.
- Counsellor: Ok, first let's check whether you are pregnant and how many weeks. Don't worry depending on that doctor will decide whether it is safe to do MTP and how to do it. Don't worry, we will try to help you out.
- Woman: Ok.
- Counsellor: So, first you go for urine test. Doctor and sister will guide you for that. Then you can come back to me and we will discuss what would be the next step. Ok.
- Woman: (Smiles) Thank You.



Episode 3 (a) Body language

- Counsellor: (The counsellor is sitting very casually, in a too relaxed position, leaning backward on a chair with her feet on a stool. She does not change her sitting position even after client enters the room and says) Yes, sit down.
What do you want?
- Woman: I am having this heavy bleeding after the MTP. That day I went home from the hospital I was all right but next day suddenly there was bleeding. I thought it will reduce but - (woman realises that counsellor is not showing any interest) - madam it is too much today.
- Counsellor: *Ha, Ha, bolo main sun rahi hoon.* (yes, go on, I am listening to you).

Facilitator's Note:

Such a relaxed posture of a counsellor does not show that the counsellor is listening. Such body language shows a careless and casual attitude, and the woman may feel dejected and lose trust in the counsellor.

As opposed to this a too tense posture also does not help in reaching out to the patient. Let's us see how counsellor's tense body position affects the counselling situation.

Episode 3 (b) Tense body position

The above episode is repeated with the counsellor showing anxiety by moving in the chair too often, fidgeting with the hands and looking tense and restless.

- Woman: Repeats the same problem as above and then when she sees the counsellor's restlessness also gets anxious and looks more tense.

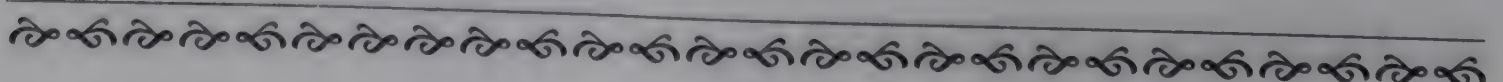
Facilitator's Note:

So now we will see what body position is more appropriate to make the client feel comfortable during a counselling session.

Episode 3 (c) Relaxed and attentive body position

The above episode is repeated with the counsellor changing her position from too relaxed to the attentive position when she sees the client entering the room. Counsellor puts her feet down from the table, moves the chair closer to the table and leans a bit forward with her hands folded with elbows on the side of the table, or on the table.

Woman repeats the same problem as in episode 3(a) but this time is more relaxed and is better able to articulate her problem.



Facilitator's Note:

We saw how the counsellor is leaning forward to relax the body and be more attentive to the client. (During this commentary the counsellor in the role play suddenly pulls her chair very close to the client's chair and the client suddenly gets alarmed and pulls her chair backward away from the counsellor).

Episode 4 (a) Distance

Counsellor: (sitting very close to the woman) Yes tell me, what is your name?
Woman: (The woman again moves her chair away from the counsellor and answers the question).
Counsellor: Tell me what happened (again pulls her chair closer to the woman's chair)
Woman: (Fumbles while talking and moves away again).

Episode 4 (b) Distance

Facilitator: Interrupts the above role play and asks the counsellor to pull his chair away from the woman's chair and points out that the woman is not feeling comfortable.
Counsellor: (Pulls her chair away to a distance of more than 4 feet from the woman's chair and asks in a loud voice) How are you feeling ? What do you want today?
Woman: (Woman looks awkward and answers in a low voice) I am okay.

Facilitator's Note:

What we just now saw is that the client may experience pressure, fear or tension, if the distance is less than 2 feet or more than 4 feet. So what is the right distance between a counsellor and a client?

Episode 4 (c) The right Distance

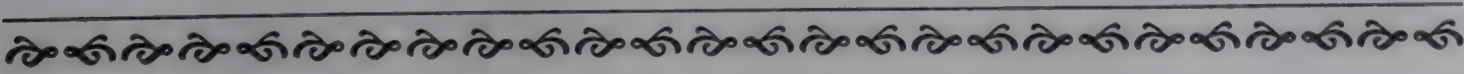
Counsellor and the client in the role play hold a measuring tape between them and adjust their chairs at a distance of 3 feet.

Facilitator's Note:

This is the right distance. Client finds it easier to talk openly, if the distance between the client and the counsellor is three to four feet.

Episode 5 (a) Attentiveness

Counsellor: (Scratching her head) Okay tell me what happened to your second child?
Client: Actually when I was pregnant second time I was not well—doctors advised bed-rest.
Counsellor: (opens the drawer of the table and starts searching for something and inbetween is nodding her head)



Client: Then I fell down and the child died—in the abdomen (Just then counsellor's cell phone rings and she attends to it. It is a casual phone call from a friend).

Counsellor: (after attending to the call, asks the same question again) Okay so what happened to your second child, you said?

Client: It died - (and starts looking down and is annoyed actually to repeat the hurtful episode again. Just then a colleague walks in and asks the counsellor whether she is busy).

Counsellor: Oh, Hi!! No, no, please come in. (Friend sits in the other chair in the room).

Friend: Did you see that last night episode of 'Ghar ghar ki kahani'? Such a sad thing.

Counsellor: I know it was really sad. I almost cried. So what else is happening?

Client: (She looks really sad, frustrated, annoyed and tries to get up saying) I will come later and walks out.

Facilitator's Note:

Counsellor's insensitivity and unattentiveness made the client walk away from the counselling session. Do you think she will like to talk about her problems to this counsellor next time? Certainly not.

Episode 5 (b)

Same episode is repeated, but the counsellor is listening very carefully to the client. When her cell phone rings she checks it, puts it off and apologises to the client and starts listening carefully. Also, when the friend walks in the counsellor tells her that she is busy right now and if there is nothing urgent, promises to visit her in the lunch time. When the friend goes away again repeats what the client was saying and asks her to continue. Client feels encouraged to talk more.

Episode 6 (a) Inappropriate use of smile

Counsellor: Yes, Usha tai, Please sit. How are you feeling today? (Counsellor smiles and asks her to sit).

Client: I am okay but look at my legs, so much swelling is there.

Counsellor: (Keeps smiling and looks at her leg. Yes, there is swelling).

Client: Yesterday I went to the market, slipped and fell down. Could not get up.

Counsellor: Oh really? (Smiles again).

Client: I was really in pain. I only know how I managed to come to the hospital.

Counsellor: (Smiling). I know it must be paining.

Client: I am really telling the truth. You don't believe me.

Facilitator's Note:

Smiling continuously or inappropriately could be interpreted as a negative response and can discourage the client from sharing.

Episode 6 (b) Appropriate use of smile

Counsellor: (Welcomes patient with a smile) Please come Usha tai. How are you feeling today?
Client: I am very happy today. I got a granddaughter. My daughter delivered yesterday.
Counsellor: Oh I am happy to hear that. Congratulations. What brings you to the hospital.
Client: But see what happened to my legs. Fell down in the market.
Counsellor: Oh!! Must be hurting. Lot of swelling.
Client: Yes.
Counsellor: Did you show it to the doctor?
Client: Yes I did.
Counsellor: That is good. I know you are very prompt in seeking treatment. Isn't it ? (smiles)
Client: Actually I came to ask you about my daughter's problem.
Counsellor: Ok. Tell me.

Facilitator's Note:

Clients feels encouraged to talk, if the counsellor smiles and nods while responding to the client.

Verbal Skills

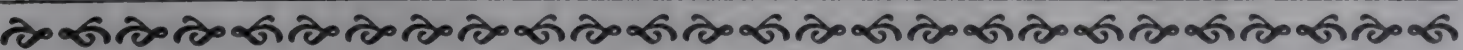
This forms 30% of our communication. Verbal skills can be used effectively along with non-verbal skills

Episode 1 (a) Allowing the client to complete the sentence

Counsellor: How many children do you have?
Client: During Ganapati festival I went to my native place. And I had my third delivery. During that delivery.
Counsellor: We will talk about that later. First tell me how many children do you have.
Client: Three - no two - I was telling you the same thing - when I went to -
Counsellor: Two or three?
Client: Three.

Episode 1 (b) Allowing the client to complete the sentence

Counsellor: How many children do you have?
Client: During Ganapati festival I went to my native place. And I had my third delivery. During that delivery my second child met with an accident. So now I have two children. But actually I had three.
Counsellor: Oh - When was that?
Client: Almost five years now. God's wish -
Counsellor: (Waits for some time) Ok. So you have two children now.
Client: Yes.



Episode 1 (b) Allowing the client to complete the sentence

Same episode is repeated but now the woman keeps talking about irrelevant things during her visit to the native place.

Counsellor: How many children do you have?

Woman: Who kya hua na,? I went to native place. My native place is very beautiful. I met that ganga mausi there. What she started telling me, that your husband is in the city he must be having an affair. I got very tensed. So then I started coming here every year. In that I got two more children. I got so fed up. My husband says not to use anything. So every year I had delivery. Last child died in the abdomen. Then my husband agreed for operation. Now I stay in the native place. I do farming. All my relatives are there. What is there in the city? But my husband does not understand.

Counsellor: One minute Usha, I understood that you like to stay in the village. We will talk more about that later. But can you tell me how many children you have.

Woman: Total four and one died.

Facilitator's Note:

If the client is wandering away from the subject it is necessary to intervene politely and direct the conversation back to the topic.

Episode 2 (a) Use of verbal encouragers

Client: You know what - actually I missed my period - and -

Counsellor: Are you pregnant?

Woman: Yes, I think so but - this child is - (client keeps silence)

Counsellor: (Keeps quiet for some time) *Ha Bolo.*

Client: I mean my lover - lover's child, I am not married to him.

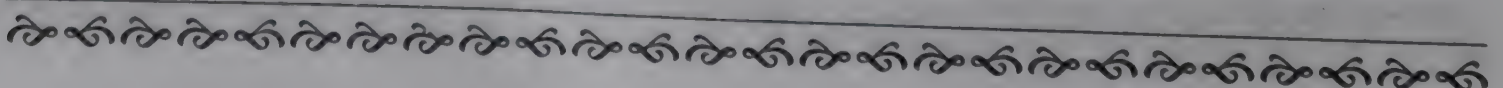
Counsellor: Uh - Uh -

Woman: Actually he ditched me and ran away. I was in love with him. We were together for 4 years. (keeps silence again).

Counsellor: After a pause. Then what happened?

Woman: Then he started suspecting my character. Now he says this is not my child. I don't want to see his face again. I just don't want this child, I want MTP.

Counsellor: You must be feeling terrible.



Episode 3 (a) Appropriate Use of Voice and Tone

- Counsellor: (To a pregnant woman) - Achha, Gauri, tell me how are you feeling? Are you eating well? And are you going for regular check-up? It's 6 months right?
- Client: Yes didi!! I am being very careful this time. You know what happened last time. Till end everything was okay and suddenly I had that pain and bleeding. I lost my child.
- Counsellor: (In a soft voice) I know Gauri. It must have been really hard for you. But remember you did not register till the last month. That is the reason I keep asking you about your health check-up. You don't lose hope. Does it help you to think of the past? Then why think.
- Client: Didi, I hope every thing goes well this time.
- Counsellor: Just keep visiting the doctor and take care of your health.
- Client: Ok.

Episode 3 (b) Appropriate Use of Voice and Tone

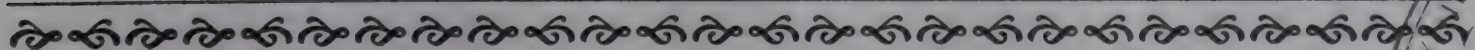
- Client: Didi!! My husband agreed for vasectomy. He said if you are having so many problems then I will go for it. I never thought he will agree. I told you he cares for me.
- Counsellor: (In a happy and loud tone) Wah! That's great!! I am really happy for both of you. Good you talked to him openly.
- Client: So when can I bring him? He has some questions.
- Counsellor: Anytime between 9.00 to 5.00. You can bring him right now or any time convenient to him. I will be happy to clarify his doubts.

Episode 4 (a) Quality of information given to the client

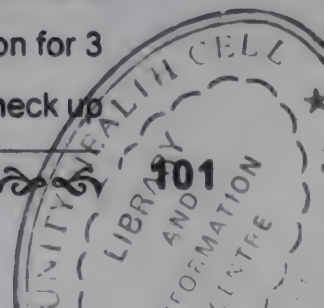
- Client: I hope I won't have any problems with the Cu-T?
- Counsellor: Not at all. I have advised so many women. No one has problems. I have never heard anyone having any problem with the Cu-T. Why worry? I am sure you won't have any problem. Otherwise why would I tell you to use it?

Episode 4 (b) Quality of information given to the client

- Client: I hope I won't have any problems with the Cu-T.
- Counsellor: Some women experience problems with Cu-T and some don't. I know many women who are very comfortable with the use of Cu-T. But there are few women who might get menstrual problems like heavy bleeding or irregular period. Many a times these problems are temporary and disappear after 3-4 months after insertion. So you have to wait and see if you get any problems. If you don't then you have protection for 3 years. The follow-up after insertion is very important. You have to come for check up



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after one month and then every six months. And whenever you feel discomfort.

But unless you try how will you know whether you have problems or not.

Client: Can I remove the copper-T if I have problems?

Counsellor: Yes, if your problem persists more than four months you can come and discuss it with me. But as I told you follow-up is very important. If you experience menstrual problems, white discharge, pain in abdomen or miss your period you should immediately report to the clinic for check-up.

Client: Maybe I should try it.

Facilitator's Note:

It is important to give the woman correct technical information rather than giving incomplete and faulty information. The woman otherwise will get information from her friends, relatives and neighbours and may form misconceptions about a method based on other people's experiences. She may not trust the health worker and that can affect her contraception decisions.

Episode 5 (a) Avoiding Technical Language

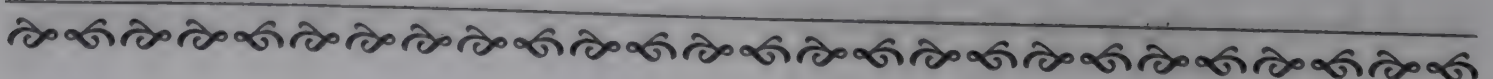
Client: I am married for two years and I don't have a child. My husband travels a lot.

Counsellor: (Explains in Hindi using a lot of technical English words) - *Dekho main aapko batati hoon ke bachha kaisa rahta hai. Dekho Aurat ke 'body' mein yeh bachhedani rehta hai. (Shows a picture) Yeh hai 'ovaries'. Is mein bahoot saare 'ovum' rehte hai. Harek Mahina is 'ovary' se ek anda bahar padta hai. Phir wo fallopian tube mein aata hai. Jise hum Ovulation bolte hai. Yeh ovulation ka time mahina aane bad 12-14 din me hota hai - Samza. To ab batau bachha rehne ka chance kabhi hota hai?*

Client: *Mujhe kya pata? Main to aapke jaise padhi likhi nahi hoon. Aap hi batao.*

Facilitator's Note:

Using language familiar to the client is an important aspect of verbal communication. It is necessary to consciously avoid using technical words. To simplify the technical information for clients is the most challenging task of a counsellor working in a health setting.

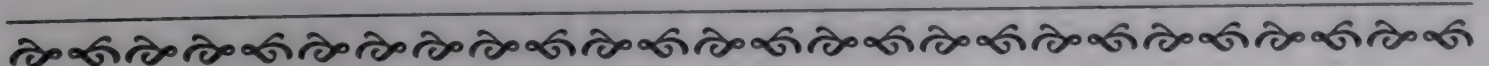


ANNEXURE 6.2

ROLE PLAY - ERRORS IN COUNSELLING

The facilitators perform the following role play and at the end of it ask the participants to list down the errors in counselling.

Roles	Dialogues	Errors
Counsellor:	Tell me how many children do you have?	
Client:	One and now I am pregnant again.	
Counsellor:	Don't lie. Only one child!! You are lying!! Tell me the truth. (<i>Ek hee bachha? Jhooth bol rahi ho kya?</i>)	Interrogating
Client:	(Scared) Why will I lie?	
Counsellor:	I know you people very well? You are from '———' community. You are liars. First of all you come to the city and then want to keep on producing more children. Do you have any brains?	Labelling
Client:	What could I do? I conceived by mistake. (<i>Kya karu? Reh gaya galti se.</i>)	
Counsellor:	Why did you not use anything (contraception)? (<i>Pehle kuchh waapra kyun nahi.</i>)	Moralising
Client:	I am thinking of going for MTP. (<i>Abhi soch rahi hoon saaf kar doo.</i>)	
Counsellor:	What do you think MTP is? Very simple?.. You should have thought earlier. You people don't have any other work so does not mean you go on producing children (<i>Aapko kya lagta hai? Saaf karna itna aasaan hai? Pehlehi sochna chahiye tha na? Aap logon ko kuchh kaam nahi hota to bachhe piada karneka hai na?</i>)	Moralising
Client:	(Feels very helpless) Then you tell me what to do. (<i>To aap hi batao mein kya karu?</i>)	
Counsellor:	If you have only one child, continue with this pregnancy. (<i>Agar aapko ek hi bachha hai to isko kyun ko saaf karna hai? Rakh lo yeh bachha.</i>)	Directing
Client:	(<i>lekin....</i>) But...	
Counsellor:	I am telling you , so you better listen. Why have you come to me otherwise? (<i>Main bol rahi hoon na - agar aapko nahi sun na hai to aap aate kyun hai hamare paas.</i>)	Directing
Client:	But my first child is very young. (<i>Lekin mera pehla bachha bahot chhota hai.</i>)	
Counsellor:	Okay then you insert Cu-t after the MTP. (<i>To phir yeh saaf karke Cu-T laga lo.</i>)	Directing
Client:	I am very scared of Cu-T (<i>Cu-T se to mereko bahoot dar lagta hai.</i>)	
Counsellor:	All this is fuss. There is nothing to get scared of Cu-T (<i>Yeh sab tumhara naatak hai. Chhodo yeh Sab bakwas aur kaamki baat karo.</i>)	Denying Feelings



Roles	Dialogues	Errors
Client :	But I am really scared (<i>Lekin...mujhe sach much dar lagata hai</i>). (Just then another woman walks in and she knows the client so she comes in and says hi to the client).	
Counsellor:	Oh! So you know her? (<i>To aap ise jaante hai</i>)?	
Other woman:	Yes, she is my neighbour.	
Counsellor:	Oh! So you must be knowing how many children she has. Tell me the truth. (<i>To aap jaanti hongi ki inko kitne bachhe hai? Aap sahi batao</i>).	
Other woman:	She has only one baby. She breast feeds her. (<i>Iska to ek hi baccha hai - doodh peeta hai na?</i>)	
Counsellor:	And you see she already conceived another and now she wants MTP. (<i>Aur suno isko doosra bhi reh gaya - Aaye hai saaf karwaane</i>).	Breaking Confidentiality
Other woman:	What you are getting MTP done? You want to kill the foetus? (<i>Kya? thaili saaf karegi, doosre bachhe ko kya maar dogi</i>)?	
Counsellor:	Ok you please wait outside. (<i>Achha abhi aap bahar baitho</i>). <i>To mein kya bol rahi thi</i> (directing to the client). Ok what I was saying is that the Cu-t does not harm in anyway. I have not heard any woman complaining. You will not have any problems. It is the best method. (<i>Cu-T se koi takleef nahi hoti hai. Mein ne aaj tak nahi suna ki kisiko cu-T se takleef hoti hai. Aap ko bhi nahi hogi - hum kyun yeha baithe hai</i>).	False Reassurance
Client :	Is there any risk in MTP? What if something happens to me - My husband may not agree at all (<i>Thaili safaa karne mein kuchh dhoka to nahi...Agar kuchh ho gaya to, Aadmi bhe nahi maanega</i> .)	
Counsellor:	That all you leave it to me. If anything happens come and tell me. What am I here for? (<i>Who sab tum mujhpar chhod do - kuch ho gaya to mere paas aane ka. Mein hoon na</i>). MTP is a safe procedure. Nothing will happen. Tell the doctor that you want MTP with Cu-T. Hurry up now. (<i>Kuchh nahi hota thaili saaf karne mein, doctor ke paas jaake bolo mujhe thaili saaf karke Cu-T lagwaani hai karke. Chalo jaldi</i>).	Encouraging dependency
Client :	Okay (<i>Thhik hai</i>) (Client walks out with a long face).	

ANNEXURE 6.3

ROLE PLAY ON VERBAL, NONVERBAL MACRO AND MICRO SKILLS

You are encouraged to adapt the following role play to suit your own context. Divide participants into four small groups. Ask each group to identify and note down one of the following:

- Non verbal communication
- Verbal communication
- Macro skills
- Micro skills

Devi is referred to you for counselling by a doctor. Client Devi is 23 years old and has a 10-month old baby boy. She has amenorrhoea since six weeks and wants an MTP, after which does not want a Copper-T inserted, as she is scared.

Client : Can I come in please?

Counsellor : (Gets up, takes the client in —> greets with a smile and says) Yes, please come in, have a seat. (Counsellor shuts the door)

Counsellor : What is your name? (Attentiveness throughout session)

Client : My name is Devi.

Counsellor : Devi, My name is _____. What brought you to the hospital today? (Counsellor leans forward and looks concerned (facial expression), while also maintaining eye contact) (Body language and eye contact)

Client : I don't want this child.

Counsellor : When was the last menstrual period? ? (Counsellor also refers to case paper)

Client : I think it was a month or a month and half.

Counsellor : Can you please tell me the exact date? Was there any festival close to the date?

Client : I think it was around Diwali

Counsellor : Diwali was last month, so may be a month and half.

Devi, you said you don't want this child—what is the problem?

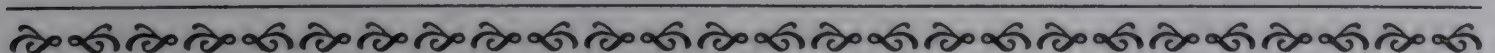
Client : I have another child who is 10 months old, and I don't want another so soon.

Counsellor : Do you know how a bag is cleaned? (How MTP is done?)

Client : Yes, by taking an injection and some tablets.

Counsellor : (Removes uterine model) Ok Devi. I will now explain to you how a child is conceived. (Demonstrates on the model). This is a Uterus. During intercourse the male penis enters till here, and when the semen comes out of the penis, it contains the sperms. These sperms travel towards the fallopian tubes. This is where the ovaries are. The female egg (Ovum) comes out of the ovaries and comes in the tube. Is that clear? If not, please ask me.

Client : I understand.



Counsellor : When the ovum and the sperm meet they come to the womb, attach themselves to the wall of the uterus and start growing. Every day their link with the wall gets stronger. As time passes the link becomes stronger and the embryo grows. Is that clear? If you have not understood anything till now you can say so. Since the embryo has attached itself so strongly it is difficult to remove it using tablets and injections. Some blood clots may come out and the rest may remain inside. As a result you may experience abdominal pain and bleeding. And the part of the embryo may still remain inside. Finally it may have to be removed in a hospital. I just told you how a MTP is done, do you want to ask any questions on this subject?

Client : No, I understood.

Counsellor : Ok, can you tell me what did you understand? So that if required I can explain it to you again.

Client : Yes, when the sperm and ovum meet and attach themselves in the uterus they hold the walls very strongly and may not come off using tablets and injections. Then it is required to come to the hospital to clean the uterus.

Counsellor : Yes, Devi, that's absolutely right. Now that you have understood how the uterus is cleaned and the risks involved do you still want to go ahead with your decision to clean the bag or do you want to continue with the pregnancy.

Client : No, I understand there could be a problem but I don't want the second child so soon, I am unable to look after two children.

Counsellor : Ok, Devi.

Client : So will they clean my thaili today itself?

Counsellor : First you will have to do your blood and urine test, depending on your reports of the tests, doctor will further advise you about MTP.

Client : All this will take very long I suppose. Why do I need to go through all these investigations?

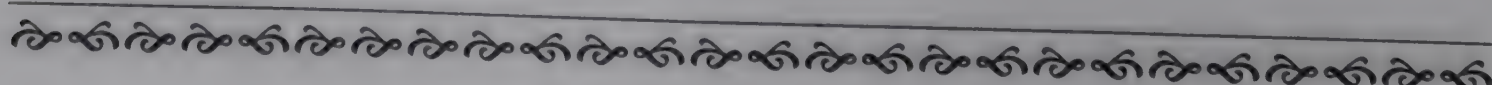
Counsellor : Your blood report will tell us about your Hb and if it is low then MTP can cause further weakness. Through Urine test we will know if there is any infection. If so doctor will first treat the infection and only then you can undergo MTP. If you have any more doubts you can ask me.

Client : Do I have to be admitted in the hospital?

Counsellor : Not right now. After seeing your reports doctor will give you a date for admission. You have to come on the previous evening and get admitted. Next day doctor will do MTP and then after you regain consciousness and if you have no other problems you can go home the same evening.

Client : Will it be painful?

Counsellor : You will be given an injection for making you unconscious, so you will not feel the pain during the operation. But after regaining consciousness you may experience some pain and weakness. You will be given medicines to take care of that.



Client : Will I be very weak? I have to do a lot of work at home.

Counsellor : You will need to rest after you go home for few days. By the way who all are there at your place?

Client : My husband and the child. He does help me in the work.

Counsellor : Ok, now tell me Devi, what do you think about preventing conception the next time if you don't want the second child soon?

Client : Don't know for sure. I will have the pills. Actually I was taking pills even now but I don't understand how I still conceived.

Counsellor : With pills you have to be very careful. If you forget to take, then you will conceive.

Client : Yes, you are right. I forgot to take the pills. I think that's the reason for the failure.

Counsellor : Apart from pills, your husband can use condom to space the children. What do you know about the condom?

Client : My husband was using it but then it tore once or twice and then there was such tension.

Counsellor : Condoms come in different types. And there is a way to use it. If worn in the right way it will not tear. You can also use Copper-T.

Client : No, no I don't want Copper-T! What I have heard is it travels up to your chest.

Counsellor : (Using uterine model and Copper-T) See, this is Uterus and this is Copper-T. Once inserted, copper-T is effective for 3 years. Then it can be removed and replaced. Can you see that it is inside the uterus and the uterus is closed from the top so it cannot go up to the chest?

Client : I have heard it causes lot of problems.

Counsellor : Not for all women. But yes, some women do get heavy bleeding during menses for first few months after insertion. It is a foreign body so our body takes some time to adjust with it

Client : But still

Counsellor : Yes, tell me ..

Client : I am scared

Counsellor : Yes, I do understand your feeling. You can think and take a decision. You can discuss this with your husband. And in case he wants more information bring him along, next time, when you come back with all the investigations. I can explain to him too so that you both can decide together.

Client : Ok.

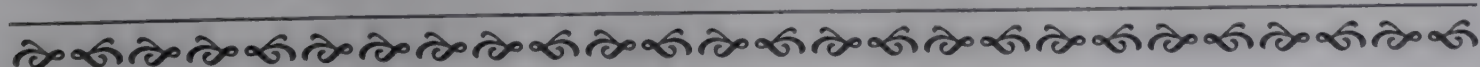
Counsellor : So today we discussed about MTP and about spacing methods. When you came back after two days and if you have any doubts don't hesitate to ask me.

Client : Ok I will go now and I will get my husband along the next time.

Counsellor : Ok so when will you come next? Today is Monday, You will get all the reports by Wednesday, so you can come with your husband in the morning between 9.00 to 11.00 a.m.

Client : Ok I will come with my husband on Wednesday.

(Counsellor smiles and stands up to see client off)



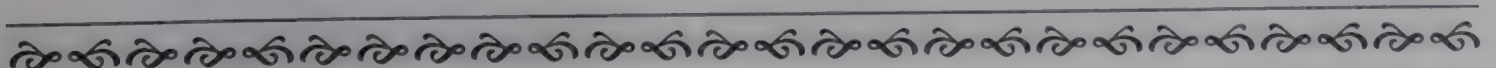
Linkages between Sexuality and Health

Most, if not all, gynaecological and reproductive health problems are ultimately linked with sexuality. Choice of contraceptive methods and satisfaction with methods, safe pregnancy and delivery, treatment of infertility, protection from sexually transmitted diseases, all have some underlying issues related to sexuality. Women's and men's sexual attitudes and behaviour influence contraceptive choice and effectiveness of use. At the same time, the use of particular methods can affect the way people experience their own and their partner's sexuality (in positive and/or negative ways).

Sexual relationships often incorporate power disparities based on gender, age, class and patronage (for example, landowner-laborers, employer-employee, upper caste-lower caste relationships). The disparities are due to both physical strength, and access to material and social resources. Girls and women have little control over what happens to them sexually. They have little control over men's sexual access to their bodies and the conditions under which their sexual encounters take place. However, the extent to which a woman is able to negotiate the terms of a particular sexual act or relationship defines her capacity to protect herself against unwanted sexual acts, unwanted pregnancy, or sexually transmitted diseases. On the positive side, it defines her ability to enjoy sex and to seek health care and family planning advice. Thus, interpersonal power relations intrinsically affect a woman's sexual and reproductive health outcomes.

Understanding Gender and Sexuality

Sexuality is the way society looks at what is basically a biological drive. It is multidimensional and dynamic. An individual's experience of sexuality is influenced by biology, gender roles, power relations, as well as age, social and economic conditions. An individual's sexuality is influenced, perhaps most profoundly by prescribed gender roles - the social norms and values that shape the relative power, responsibilities and behaviours of men and women. For example, women's prescribed role in sexual relations is to be passive. Women are not encouraged to make decisions regarding their choice of sexual partners, to negotiate with their partners the timing and nature of sexual activity, to protect themselves from unwanted pregnancy and disease, and, least of all, to acknowledge their own sexual desire. Men on the other hand are socialised to 'conquer' to prove their manhood. Men are encouraged to think primarily of sexual performance; women's sexual pleasure is valued usually as proof of male performance. Also, the proof is sought in the form of fertility—ability to have children, that too, male babies.



Men's, and women's, mutually reinforcing gender roles have particularly debilitating consequences for reproductive health and contraceptive practice. These roles place a woman's health at risk when they lead her to neglected health, gender-based abuse and violence, harmful practices such as rape and other forced sex, STDs, unwanted pregnancies and unsafe abortions.

Barriers to talking about Sexuality

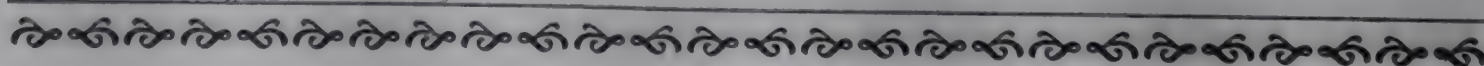
Despite the close links between sexuality and health, discussions on sexual issues are generally left out in health provider - patient interactions. Or if it takes place at all, the concept of sexuality is reduced to the notion of sexual intercourse and peno-vaginal penetrative sex in heterosexual relationships. Some of the reasons why sex and sexuality are never discussed are :

- These are considered a very private area of one's life and very early in life, we are socialised to hide our sexual selves and to be silent about this aspect of ourselves.
- Sexuality is an area which is tightly wrapped by morality and societal prescriptions of what is 'good' and 'bad'. These moralistic values and attitudes prevent us from really expressing our true opinions around sexual matters.
- There seems to be a lack of an acceptable language to talk about sexuality. While on the one hand, there is a rich stock of metaphors and terms related to sexuality in most subcultures, these are inaccessible to persons outside those subcultures. On the other hand, common terms related to sexuality in the vernacular languages sound crude and also have the connotation of 'bad' words and abuses and not considered acceptable for use by 'decent' people.

Because of the reasons described above, health care providers generally do not talk to patients about the sexual dimensions of their health conditions. If they do, they may talk about these in highly sanitised bio medical terms, bereft of all emotions, which remove the discussion from the arena of daily life experiences.

Learning to talk about Sexuality

Health care providers need to be equipped to talk sensitively about matters related to sexuality. Firstly providers need to understand how elements of sexuality like *sexual partnerships*, *sexual acts*, *sexual meanings*, *sexual drives and enjoyment* affect reproductive and sexual health outcomes (Dixon Mueller, 1993). For example, providers need to know about the range of the clients' sexual partnerships (with both the same and the opposite sex) and practices, if they are to offer appropriate advice on protection from disease as well as from pregnancy. Clients should be asked routinely about genital discharge or sores, and whether they experience pain or discomfort during intercourse or other sexual acts and providers should not feel uncomfortable when clients ask for information and advice.



Secondly, just as clients' sexual attitudes and behaviours affect their reproductive health, providers' sexual activities and values influence the quality of their service e.g. Providers may withhold contraception or abortion services from sexually active, unmarried women, or fail to deal realistically with STD prevention if a client is homosexual.

Training modules for providers should include basic information about sexual functioning (physiology, male and female sexual response, capacity for orgasm), about life cycle changes in sexuality, fertility and menstrual patterns. Training on perspective and attitudes is equally important: Health care providers need to examine their own attitudes, biases, and values related to sexuality so that they reflect a non-judgmental and supportive stance in their interactions with their clients. Thus training of health care providers has to be built around self-reflection and self-examination to their own sexuality followed by sharing personal opinions, values, attitudes, and experiences.

Going through such a process gives words to personal experiences and will help health care providers adopt the same process with their clients making it an extension of a common human experience.

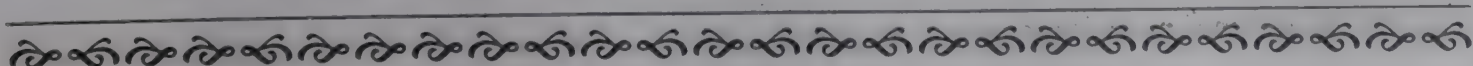
Sexuality Counselling

This section describes the essential elements of Annon's PLISSIT model (IPPF, 1992). This model suggests that clients need PERMISSION as an acknowledgement of their need for intimacy and a validation that their sexual concerns are normal. They need LIMITED INFORMATION of the factual kind to address their sexual issues. Further they need SPECIFIC SUGGESTIONS for ways to induce behaviour changes. In ideal conditions, the counsellor and the client work together to find satisfying solutions to overcome barriers to sexual functioning, including alternatives to intercourse. If problems cannot be managed through the stages of PERMISSION-GIVING, INFORMATION PROVISION and SPECIFIC SUGGESTIONS, clients may have to be referred for INTENSIVE THERAPY.

Permission giving is an important task of sexuality counselling because people need to hear from someone 'in authority' that what they are feeling, thinking or doing is normal, that sexuality is acceptable and not a sign that they are mad or deviant or dangerous. Realising that their feelings, thoughts or behaviours are acceptable to the counsellor can be the beginning of self-acceptance for the client. Women need Permission to accept that they have a right to sexual pleasure. Women also need Permission from the counsellor to express their 'no' in sexual relationships.

Women may need permission:

- to talk about their sexual feelings in the first place.
- to have (or not to have) sexual feelings and or fantasies.
- to do (or not do) particular sexual things.
- to like (or dislike) particular terms of sexual expression.
- to respond physically to sexual stimuli.



Sometimes peoples' difficulties with sexuality relate to a lack of information, or to inaccurate information. In many societies a range of myths exist about sexuality. Myths are commonly held beliefs that are assumed to be facts. Because of strong taboos which exist in many cultures on talking about sexuality, many people are likely to be sexually ignorant and such ignorance can lead to anxiety, fear and feelings of total isolation. Providing the relevant information in an empathetic way can go a long way to resolving difficulties related to sexuality. Care should be taken to ensure that the information provided is directly relevant to the client's immediate concern. For instance, many young persons believe that masturbation results in weakness and illness and feel extremely guilty because they masturbate. It is important to provide them with scientific evidence rejecting that masturbation leads to mental illness or any other problems.

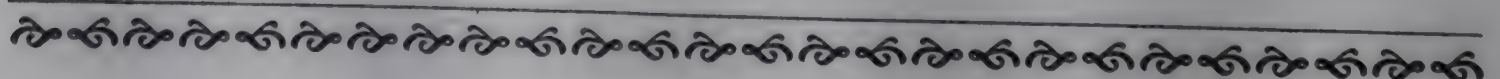
There are times when it is appropriate for counsellors working with clients with sexual difficulties to make specific suggestions that fit with the client's sexual feelings, thoughts and behaviours. Suggestions need to be sensitive to prevailing cultural beliefs and taboos about body and sexuality. At the same time, they may also gently challenge these.

All sexuality counselling which is woman centred must strive to help the partners to transform the traditional gender roles and societal notions of male and female sexuality and explore the dynamics of power within a particular relationship so that there is greater negotiation between partners and they move towards equitable power relations. Equitable power relations cannot be expected to become a reality within a short span of time or without the involvement of men. Therefore, women need to be helped on an on-going basis, so that they become committed to self-empowerment. Also, their partners need to be taken into confidence and convinced of how they stand to gain by improving power relations with their partners. They can have a more fulfilling partnership. Male health workers (MPWs) have a very important role to play in counselling the male partners of the women clients who come for counselling.

Module Objectives

At the end of this module, the participants will

- understand the links between sexuality and reproductive and sexual health
- understand how male and female sexuality is constructed i.e. how gender norms influence characteristics of male and female sexuality
- become aware of their own attitudes and biases in relation to sexuality and the notion of sexual rights
- increase/improve their skills in talking about sexuality and counselling women in the OPD.



Session 1 Concept of Sexuality

Learning Objectives

- At the end of the session participants will
- describe the various dimensions of sexuality
 - understand that sexuality is a multi dimensional concept.

Time 60 minutes

Resource Cards— 3 per participant, OHT 7.1

Methodology

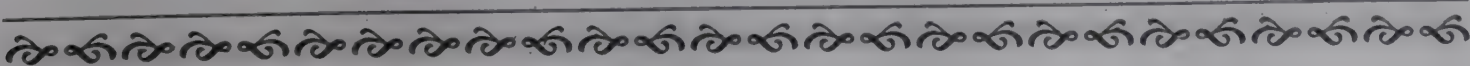
Brainstorming and word association

1. Facilitator distributes 3 cards to every participant and asks them to write three words that come to their minds when they think of SEXUALITY. Each card should contain one word or phrase.
The words that emerge will fall into categories like:
Body parts, Physical aspects, Feelings, Beliefs and meanings (e.g. bad, secret, sinful). Sexual behaviours or acts (e.g. masturbation, kissing), Sexual identities or orientations (e.g. homosexual) Use of power (rape, sexual harassment, violence). Many other categories can emerge.
2. Ask each person to read out their cards and stick them on the wall in clusters of categories. Do not name the categories yet.
3. When all participants' cards are up on the wall, ask participants to review the clusters and name the categories.
4. Add any aspects that you think have been left out e.g. PLEASURE or FANTASY
5. Sum up by saying that Sexuality is a multidimensional concept, (have all the dimensions portrayed on the wall).
6. Establish that it is different from Sex which generally refers to sexual intercourse between a man and woman.
7. Show OHT 7.1 - What is Sexuality?

What is Sexuality?

Sexuality is more than sexual behaviour. Sexuality encompasses eroticism, sexual behaviour, social and gender roles and identity, relationships, and the personal, social and cultural meanings that each of these might have. (Chandiramani et al, 2002)

8. State that it is this wider understanding of the concept of sexuality that should guide our interventions.



Facilitator's Note

Sexuality is a difficult concept to talk about. The participants may be hesitant to share. Go along with them, do not push too hard. Try and create a safe and non-judgmental atmosphere so that participants with extreme views also feel emboldened to share. Do not give the examples at the beginning. These are only for your understanding. Give examples only if participants are stuck.

Points to Emphasise

- 'Sexuality is a multidimensional concept, more than sex'
- We need to be aware of each dimension when we plan our interventions like counselling or training

Session 2 Gendering of Male and Female Sexuality

Learning Objectives

- At the end of this session participants will be able to
- describe the difference between male and female sexuality.
 - understand how male and female sexuality is socially constructed.
 - analyse the double standards that underlie how society perceives male and female sexuality.

Time 60 minutes

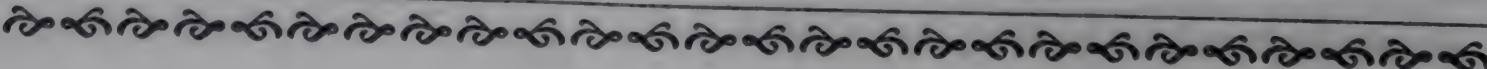
Resources Blackboard / Whiteboard and chalk / Markers Cards

Methodology

- Brainstorming, interactive discussions, listing
1. Facilitator introduces the session to the participants saying "we are going to look at whether male and female sexuality are different. And if so, what are the differences?"
 2. Facilitator asks participants to state what they believe about male sexuality and what they believe about women's sexuality and starts listing responses in two columns on the board.

The following are some typical responses.

Male Sexuality	Female Sexuality
<ul style="list-style-type: none">• Aggressive• Difficult to control• Always initiates• Has to 'know' everything• Exhibitionist, conqueror, many conquests• Virility, masculinity associated with high sexual activity	<ul style="list-style-type: none">• Passive• No desire or urge• Cannot initiate• Has to be pure, chaste• Modest• 'Good' woman vs. whore• Sexual activity allowed only within marriage and for child bearing



3. Facilitator asks participants whether they see any connections between gender and female and male sexuality as listed on the board. Through discussions, facilitator establishes that male and female sexuality are not biologically given but are socially prescribed.
 4. Facilitators asks participants to recall any proverbs or sayings from their cultures that describe different characteristics of male and female sexuality and write these on cards. E.g. *Apne khet ka khud khayal rakho*, (look after your field yourself), *Saandh paala hai to dand bharenge* (male can do anything, we will provide space for this and pay fine for this), *Khoonta agar mazboot hai to bhains idhar udhar nahin jayegi* (If the nailpost is strong, the buffalo won't stray hither and thither).
- The cards are read out one by one and later pasted on wall.
5. Facilitator asks participants on whether they see any differences in standards by which society judges male and female sexual behaviours. E.g. a girl must be a virgin at marriage but a boy must know everything and be experienced. It was considered okay for kings to have many wives and many children by their many wives, but a queen could not have many husbands.

Facilitator's Note

Once again, try and establish an atmosphere wherein participants can venture to share their views without feeling judged.

Points to Emphasise

- Sexuality is socially constructed and not biologically determined.
- There are double standards by which society judges male and female sexual behaviours

Session 3 Links between Sexuality, and Reproductive and Sexual Health

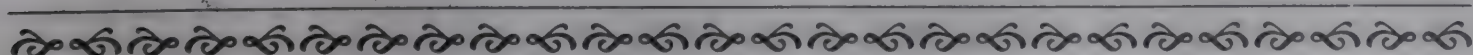
Learning Objectives

At the end of this session participants will be able to

- identify how various RH conditions are linked with sexuality
- describe the barriers faced by health care providers in addressing issues related to sexuality
- list ways of overcoming the barriers

Time 60 minutes

Resources Blackboard, Chalk



Methodology

1. Facilitator asks participants to list various reproductive and sexual health problems and conditions. These are listed in one column on the blackboard.
2. For each of these, the facilitator asks whether there are any sexuality issues related to the particular condition. The facilitator lists these in the second column,
3. The facilitator summarises by saying that many RH problems/conditions have underlying sexuality dimensions. And yet what do we, as health care providers, do about these?
4. Facilitator encourages participants to list all the barriers that they perceive prevent them from addressing sexuality issues. These are listed on the black board. The facilitator states 'Let us think about these barriers and what can be done to overcome them - we will see how to address them in a later session.'
5. Facilitator gives inputs based on Ruth Dixon Mueller's 'Linkages between the Sexuality/gender framework and reproductive health' (OHT 7.5).

Points to Emphasise

Each reproductive health condition, from contraception to infertility to pelvic inflammatory disease to pregnancy and ante natal care, has some underlying sexuality dimensions. It is important for health care providers to be able to talk about these so that clients can raise these issues with them.

Session 4 Exploring Attitudes Related To Sexuality

Learning Objectives

At the end of this session participants will

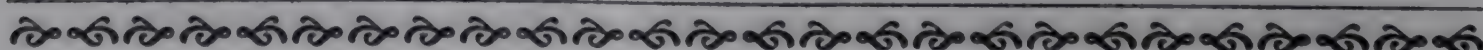
- state their own values around sexuality
- discuss and begin to accept aspects of sexuality, which were hitherto unacceptable to them
- articulate the principles of acceptable and unacceptable sexuality

Time 60 minutes

Resource Sheet with statements (Handout 7.1)

Methodology

1. Divide participants into four groups and distribute 3 statements from Handout 7.1 to each group for discussion and arriving at consensus.
Group discussions will take 30 minutes.



2. In the plenary, take up each statement. First get the group's opinions with reasons. Then throw open discussion to larger group. Give your input.
Discussion on 12 statements will take up to 45 minutes.
3. Elicit principles of what is acceptable, and what is absolutely not acceptable in relation to sexuality.

Acceptable : respect, caring and mutual consent, 'safe'

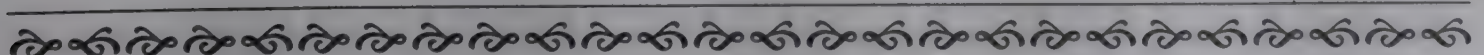
Unacceptable : use of force, non-consensual, wide power differentials
(e.g. child and older persons, junior person and boss), 'unsafe'

Points to Emphasise

- Value and attitudes towards sex and sexuality are deeply internalised. We need ongoing reflection in order to become aware of them and how they affect our behaviour towards others.
- In accordance with principles of tolerance and respect for diversity we need to learn to accept others whose ideas of sexuality do not match ours.
- Use of force and power in sexual relationships is absolutely not acceptable.

Facilitator's Note

By the end of this session participants will feel free to state their beliefs and values. For value clarification to take place sufficient time should be kept for discussion.



1. *Men are by nature polygamous but women should be faithful*

This statement is constructed illogically. While the first part 'men are by nature polygamous' purports to be a fact, the second part 'women should be faithful' is prescriptive. Men's polygamous nature is a social construct and not quite a biological fact. Women's prescribed faithfulness is also how society demands they be. And why can't there be the same set of standards for both men and women?

2. *Homosexuals are abnormal and rare*

A homosexual is a person who is attracted to people of the same sex and derives sexual pleasure from them. Both men and women can have such an attraction. At different times in a person's life they may find they are attracted to different kinds of people. At some time in most people's lives they will experience some level of attraction to others of the same sex. Homosexuality is quite common and should be considered normal.

3. *Most women with HIV are sex workers*

No, no. not at all. The nature of the epidemic has changed. Ordinary, 'faithful', monogamous wives are today at grave risk of the HIV infection brought onto them by the risky behaviour of their 'polygamous' husbands..

4. *Masturbation leads to weakness*

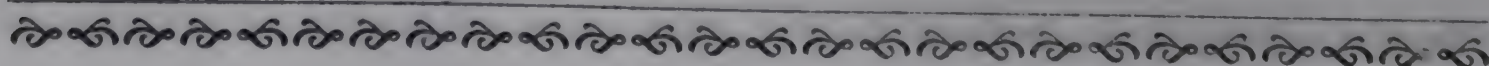
It is a normal sexual activity practiced by both males and females. If it leads to weakness, the weakness is due to the guilt and shame of masturbating and not due to loss of semen, as is commonly believed.

5. *A girl should not have sex before marriage*

And what about a boy? Can he have sex before marriage? Why is he allowed to have sex before marriage and a girl is not? Why the double standards? Boys too should not have sex before marriage, lightly and loosely. We must promote the same standards of respect, dignity, safety and responsibility for both boys and girls.

6. *Sexually explicit literature or visual material corrupts the mind and should be banned*

Banning anything has been known to push it underground. So banning is not the answer. Sexually explicit literature, which is scientific and respectful of men and women, is required for sex education. We have to ensure that material that does not objectify women should be produced.



7. *Women should stay indoors to be safe from sexual abuse*

What about so many women who stay indoors with their husbands and are victims of marital rape? What about the number of girls who are victims of child sexual abuse within their homes, often at the hands of people who are known to them? That homes are safe havens for women, is a myth.

8. *When women say "no" they may actually mean yes*

Until women have the societal permission and freedom to say yes, their 'no' will never be taken seriously. Women are not allowed to express their sexual desires. Any woman who does so, is considered loose and wanton. The argument given above 'When women say "no" they may actually mean yes' is what is typically used by men who rape women: 'she was enjoying it.'

9. *The main purpose of sex is to have children*

Then there should be many more children in this world, right? Enjoyment and pleasure are the main reasons to have sex. Actually it is Religion that dictates that the main purpose of having sex is procreation. And therefore sex is permitted and legitimised only within marriage and only till childbearing is over. All other sexual activity is considered either sinful or indulging one's sensuous desires.

10. *Women who are sexually teased or abused, act or dress provocatively*

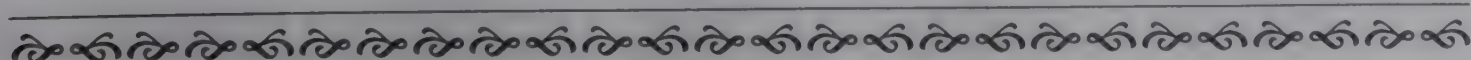
What about little girls and older women? Many of them without dressing provocatively are victims of sexual abuse. And what does 'dress provocatively' mean? Dressing for the pleasure of looking and feeling good is taken to mean 'dressing provocatively'. And who decides what is dressing provocatively? Generally, it is men and the patriarchal mindsets who want to control women who lay down dress codes for women in society.

11. *The vagina is the most sexually sensitive organ of the female*

No, women can have many erogenous zones. Different women feel aroused with touch on different parts of their bodies. Those who are sensitive to their partners' sexual pleasure will take the time to discover what is pleasurable for their partner. Fewer than 30% of women are ever able to achieve orgasm through vaginal penetration. The clitoris is the primary sexual organ of a woman. It has no other function than to provide sexual pleasure.

12. *Oral and anal sex are unnatural*

No, different people have different preferences. As long as there is mutuality and consensus any sexual act is natural. In our opinion, rape and non-consensual sex is unnatural.



Alternative B

Small group exercise on Mapping Sexual Hierarchies

Exercise contained in Handout 7.2

Material required

Chart paper and markers for Sexual Maps.

Copies of Handout 7.2.

Time

2 hours

Activities / Steps

Step 1 Small group exercise on Mapping Sexual Hierarchies

- Divide participants into 3 or 4 small groups.
Each group should come out with a listing of 'From society's perspective *most acceptable to least acceptable* forms of sexual relationships'.
Around 45 minutes will be required for group work.
- Let each group present their sexual map with their explanations.
- Facilitator asks what did we learn out of this exercise.

Example of Sexual Map

Most Acceptable

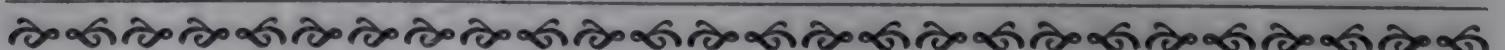
- relationship between heterosexual married person of same caste, class, for procreation.
- sex before marriage for males.
- sex outside marriage for males.
- sex outside marriage for women.

Least acceptable

- same sex relationships.
- sex with animals.

Some Learnings

- What are the social norms around sexuality, depending on worldviews and contents?
- What is considered 'deviant' or 'abnormal' 'sexuality'?
- Double standards around sexuality.



Step 2

- Give out Handout 7.2 and ask participants to complete the exercise contained therein in 10 minutes.
- Conduct a large group discussion on what participants learnt about themselves while doing this exercise.

Facilitator's Note

1. All erotic behaviour is considered bad unless a specific reason to exempt it has been established. The most acceptable uses are marriage, reproduction and love.
2. Individuals whose behaviour stands high in the hierarchy are rewarded with certified mental health, respectability, legality, social and physical mobility, institutional support and material benefits.
3. As sexual behaviours or occupations fall lower on the scale, individuals who practice them are subjected to a presumption of mental illness, disreputability, criminality, restricted social and physical mobility, loss of institutional support and economic sanctions.
4. Sometimes it is the fear of stigma that gives certain sexual behaviours a low status. However stigma is also a result of religious traditions.
5. Medicine and psychiatry also reinforce the stigma. The section of psycho-sexual disorders in the Diagnostic and Statistical Manual of Mental and Physical Disorders (DSM) of the American Psychiatric Association reflects the current moral hierarchy of sexual activities.
6. Sexual morality has more in common with racism than true ethics. It grants virtue to the dominant groups and relegates vice to the underprivileged.
7. A democratic morality should judge sexual acts by the way partners treat each other, the level of mutual consideration, the presence or absence of coercion, and the quantity and quality of pleasure they provide.

(Gayle S. Rubin, 1999)

Session 6 Sexual Rights

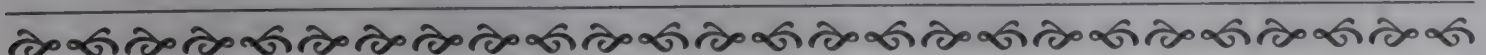
Learning Objectives

By the end of the session, the participants will be able to

- define the concept of sexual rights and the underlying values and principles of sexual rights.
- begin using the sexual rights' framework.

Time 90 minutes

Resources OHTs 7.2, 7.3, 7.4



Activities

Step 1

- Facilitator presents a brief history of sexual rights, definition and values underlying sexual rights based on OHT 7.2 & 7.3.

Step 2

- Facilitator divides participants into small groups and asks them to draw up lists of important Sexual Rights from their own contexts (15 minutes).
- Small groups share their lists and facilitator consolidates these using OHT 7.4

Step 3

- Facilitator asks participants how they could use the sexual rights framework in their work situations.
 - *As managers of organisations, would your personnel policies include pregnancy/maternity leave for any woman (including single women)?*
 - *As health care providers, what would you do to ensure contraceptive services or abortion services to single women and men?*
 - *As landlords would you rent your house to a gay couple?*

Facilitator's Note

You might be asked to address the question 'Are not Sexual Rights a western concept and western agenda? We have more important problems in our country, why are we bothered about Sexual Rights?' You can reply by taking up the example of hijras and how they are discriminated against in our country. They are made fun of and feared sometimes. Do they not have a right to be treated with dignity and respect?

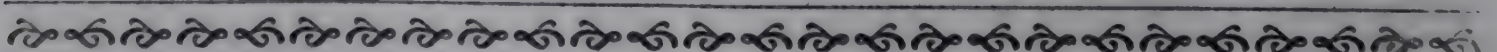
Session 7 Developing a Sexual Vocabulary

Learning Objectives

At the end of the session participants will be able to

- state various words related to sexuality or having sexual connotations.
- increase their comfort levels with the words and become more at ease with these.
- describe the social conditioning we go through about sex.

Time 45 minutes to 1 hour



Methodology

- (1) One by one, write the following items on a piece of flip chart paper:
vagina, penis, sex, semen, erection, masturbation, orgasm, breasts, testes.
After writing each word, ask the participants to react with whatever thoughts, feelings or associations they may have about them. Write down the words or feelings they express (e.g. with “sex” they may associate *dirty, enjoyable, children*, etc.)
- (2) Ask the participants to brainstorm words or phrases of their own that have to do with sex – Hindi/other local language and English slang, technical, anything, and repeat the process of recording their response as above.
- (3) Ask participants to read out the lists one by one. Facilitate a discussion about the words and their response.
- How did it feel to use these words?
 - Which words were the hardest to say? Why are these so difficult?
 - What kinds of people use these words?
(Good people/bad people/doctors/adults with each other/ children or young people with each other/women/men/mixed groups)
 - Which words are they most happy with? (Words I like. Words I don't.)
 - Why are there such different - even contradictory - responses to the words?
 - Are there words which are used to abuse others? In what instances are the words used as terms of abuse ?
 - What are the cultural and sexual attitudes that are revealed in the language we use?

This final question can be enhanced by calling out a word and asking the participants for the equivalent word for the opposite sex. Why are there no equivalents? Possible words could include the following, but think about examples in your local language/the language of your participants, as well:

WOMEN

Slut Nymphomaniac Whore

MEN

Stud Gigolo Pimp

(Source: NAZ Foundation, 1996, Guide to Teaching about Sex and Sexuality)

Points to Emphasise

The facilitator points out that when we work with sexual health issues, we have to be comfortable using certain words that are generally perceived as offensive.

Session 8: Sexuality Counselling

Learning Objectives

At the end of the session participants will be able to

- apply principles of woman centred counselling to sexual health issues.

Time 90 minutes

Resource Blackboard, chalk.

Methodology

1. Facilitator generates principles of woman-centred sexuality counselling from the group and lists them on the board. (See the section on Sexuality Counselling and Chapter 5 on Woman Centred Counselling.)
2. Facilitator divides participants into 4 or 5 small groups. Each group is given a case study of an OPD patient and has to apply the listed principles of woman centred sexuality counselling. Role plays have to be prepared.
3. Role plays are presented by each group. Other members are asked to observe and present positive feedback first and then suggestions for better counselling.
4. Facilitator summarises by going back to the principles on the blackboard and adding more from the feedback if any are missing.

Facilitator's Note

Woman Centred Sexuality Counselling

Women need permission to accept that they have a right to sexual pleasure. Women also need permission from the counsellor to express their 'no' in sexual relationships.

Women may need permission:

- to talk about their sexual feelings at all.
- to have (or not to have) sexual feelings and or fantasies.
- to do (or not do) particular sexual things.
- to like (or dislike) particular terms of sexual expression.
- to respond physically to sexual stimuli.



Case Studies

If you are in-charge of this OPD and have been through this counselling training, what would you do differently?

Case Study 1

In the internal examination room

While checking, the doctor asked, "Do you want this baby?"

Patient said, "yes, doctor saab."

Then the doctor saw her case paper and said (in a raised voice), "You have two children already. Two children are enough. Don't you understand?"

Patient said, "If my husband wants, what can I say?"

Case Study 2

Lalita (age 28 years) is pregnant for the third time. She lost her previous two pregnancies due to miscarriage. She comes to the ANC clinic complaining of spotting. The doctor tells her not to have sexual relationship with her husband. Her husband is waiting outside the OPD.

Case Study 3

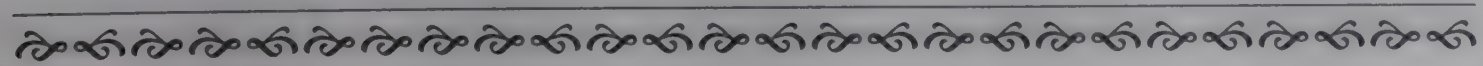
A woman comes to the OPD with her old case papers. Doctor sees her papers and tells her, "your report is okay. No problem with you, but there is a problem with your husband's report. He has problem with the dhatu (semen)." Doctor asks her to call her husband. The husband comes in. There are many women around the doctor's table and both the doctors in the OPD are women. The doctor tells the husband, "your sperm count is less. You have to take treatment. With the treatment it will increase. I am also giving treatment to your wife. She has to take these tablets on the 10th day of her menstrual cycle and continue for one week, you need to have intercourse from the 10th day for one week. You have to take the medicine for three months and then we will again do the test and see if sperm count increases."

Case study 4

Sushma and Raju, a young couple, come to you for contraceptive advice. During the course of your conversation, you discover they are not married. What will you do?

Case study 5

Krishna, a 47-year-old woman is suffering form rheumatism and excessive bleeding. You also find out that she is diabetic. She feels exhausted after sexual intercourse and does not know how to tell her husband. What will you do?



Alternative Session Plan for Session 8 - Sexuality and Health

Learning Objectives

- At the end of the session participants will
- know the concepts of sexuality and it's various dimensions and complexities
 - realise the importance of discussing issues related to sexual practices in most of the gynaecological conditions
 - clarify their values related to sexuality and understand its effect on their work as health care providers

Time 2 hours

Resources OHT 7.5 explaining the linkage between sexuality and reproductive health, list of statements for value clarification - Handout 7.1 and Handout 7.2

Methodology

1. The facilitator asks the participants to think of a word, phrases, feelings associated with the word sexuality.
2. The words associated are listed on the board and the facilitator brings out the various dimensions of the term sexuality.
3. Participants are then asked the reasons why they are not comfortable discussing these issues with clients.
4. Facilitator asks the participants to list gynaecological conditions associated with sexuality, and hence establishes importance of talking about the issue and being comfortable with it.
5. Participants are then divided into 3 groups. Each group is asked to discuss 3 statements from the list of statements (Handout 7.1) and share the views in the larger group.
6. In the presentation, discussion is held on the reasons for agreement or disagreement related to the statement.
7. After this exercise the participants are given a list of statements on sexuality, sexual behaviours and practices (Handout 7.2). They are individually asked to specify whether they would accept the behaviour for self, or they will not accept for self but do not mind if others prefer it and the third option is it is not acceptable for self and others. The data of this exercise is then collated and presented back to the group and the group is asked to reflect on the values of health care providers. Some of the statements are discussed in the group.

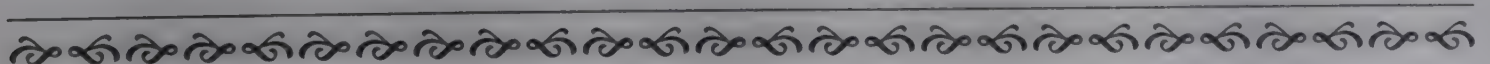
Facilitator's Note

Use the explanations given on pages 82 and 83 for each statement.



References

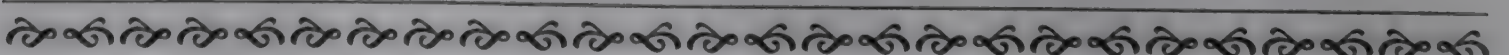
1. Dixon Mueller, Ruth, (1993): **The Sexuality Connection in Reproductive Health**, *Studies in Family Planning* 24, no. 5: 269-82.
2. Zeidenstein, Sondra and Kirsten Moore (ed) (1996): **Learning about Sexuality: A Practical Beginning**, Population Council/International Women's Health Coalition, New York.
3. Annon, Jack, Sexuality Counselling- the PLISSIT Model (1992), in **Counselling and Sexuality**. A video-based training resource, International Planned Parenthood Federation, London.
4. Naz Foundation (India) Trust (1996), **Guide to Teaching about Sex and Sexuality**, New Delhi.



HANDOUTS 7.1

STATEMENTS

1. Men are by nature polygamous but women should be faithful
2. Homosexuals are abnormal and rare
3. Most women with HIV are sex workers
4. Masturbation leads to weakness
5. A girl should not have sex before marriage
6. Sexually explicit literature or visual material corrupts the mind and should be banned
7. Women should stay indoors to be safe from sexual abuse
8. When women say "no" they may actually mean yes
9. The main purpose of sex is to have children
10. Women who are sexually teased or abused act or dress provocatively
11. The vagina is the most sexually sensitive organ of the female
12. Oral and anal sex are unnatural



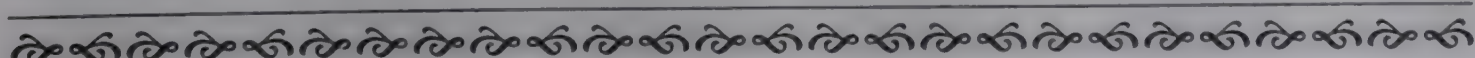
HANDOUT 7.2

EXERCISE: PERSONAL REFLECTION ON VALUES AROUND SEXUALITY

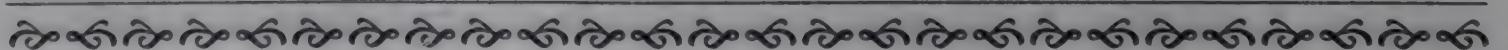
Instructions

- (i) Given in the boxes below are some aspects/behaviours related to sexuality. In each box mark
- + okay for me,
 - ? Maybe/ maybe not OK for me
 - 0 not okay for me but okay if others do this
 - x under no condition, is this acceptable to me
- (ii) After marking each box, reflect on what you learnt about yourself.
- (a)
 - (b)
 - (c)
- (iii) Share your learnings in the large group only if you wish to.

Kissing		Oral Sex	
Masturbation		Sexual relationship with minor	
Anal sex		Read or view sexually explicit material	
Hugging and caressing		Hugging HIV positive person	
Have sex with person of same sex		Forcing sex	
Have sexual relationship before marriage		Forcing partner to have sex despite his/her wishes	
Ask for a HIV test of a person you would marry		Have sexual relationship with person other than partner	
Complimenting opposite sex for looking/dressing attractively		Telling partner what gives you greatest sexual pleasure and ask him/her to do it for you	
Hugging persons of same sex to show affection		Have a love affair	



Refuse to have sex with your partner		Hugging a person of opposite sex to show affection	
Holding hands of partner in public		Hugging partner in public	
Sex in exchange of favors		Wearing salwar-kameez without dupatta (women) or shorts (men) in front of mother-in-law	
Using abusing words-describing sex with the mother		Have a commercial sex worker as a friend	
Share sexual problems with partner		Stay back in office till late at night with a colleague of the opposite sex	
Have a homosexual friend		Discuss a sexual problem with a colleague	



OVER-HEAD TRANSPERENCIES

OHT 7.1

WHAT IS SEXUALITY?

Sexuality is more than sexual behaviour. Sexuality encompasses eroticism, sexual behaviour, social and gender roles and identity, relationships, and the personal, social and cultural meanings that each of these might have.

(Chandiramani et al, 2002)

OHT 7.2

SEXUAL RIGHTS

"Sexual rights are a fundamental element of human rights. They encompass the right to experience a pleasurable sexuality, which is essential in and of itself, and, at the same time, is a fundamental vehicle of communication and love between people. Sexual rights include the right to liberty and autonomy in the responsible exercise of sexuality".

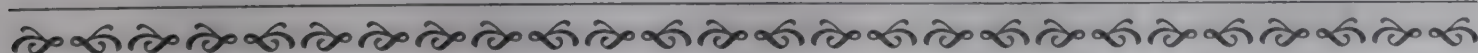
HERA Statement

OHT 7.3

PRINCIPLES OF SEXUAL RIGHTS

Based on certain ethical principles –

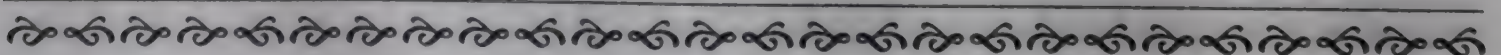
1. Bodily Integrity – the right to security in and control over one's body. This means that all women and men have the right to not only be protected from harm to the body but also to enjoy the full potential of the body.
2. Personhood – the right to self determination. This means that all women and men have a right to make decisions for themselves.
3. Equality– all people are equal and should be recognized as such without discrimination based on age, caste, class gender, physical ability, religious or other beliefs, sexual preference or other such factors.
4. Diversity – respect for difference. Diversity in terms of peoples' sexuality and other aspects of their lives should not be a basis of discrimination. The principle of diversity should not be misused to violate any of the previous three ethical principles.



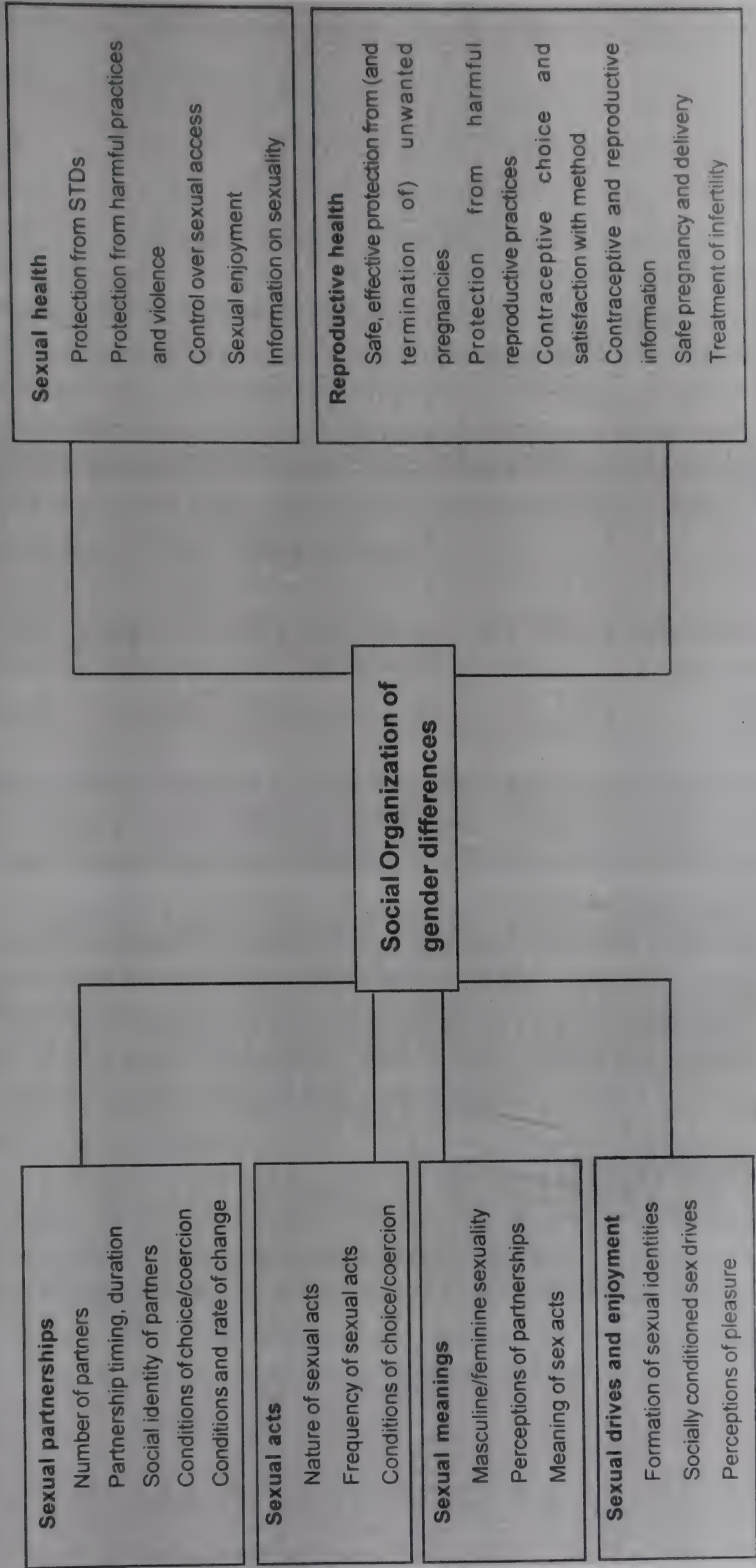
OHT 7.4

SEXUAL RIGHTS INCLUDE:

1. The right to sexual pleasure without fear of infection, disease, unwanted pregnancy, or harm.
2. The right to sexual expression and to make sexual decisions that are consistent with ones' personal, ethical and social values.
3. The right to sexual and reproductive health care information, education and services.
4. The right to bodily integrity and to choose, if, when, and with whom to be sexually active and engage in sexual relations with full consent.
5. The right to enter relationships, including marriage, with full and free consent and without coercion.
6. The right to privacy and confidentiality and seeking sex work and reproductive health care services.
7. The right to express one's sexuality without discrimination and independent of reproduction.



LINKAGES BETWEEN THE SEXUALITY-GENDER FRAMEWORK AND REPRODUCTIVE HEALTH



Gynaecological Out Patient Departments (OPDs) receive patients for consultation for different conditions. The services offered at the OPD range from family planning advice to complicated surgeries of the reproductive system. Every woman comes to the OPD with the expectation of getting immediate relief from the pain or discomfort that she is experiencing, and seeking advice on decisions related to family planning methods—spacing as well as permanent—or opting for medical termination of pregnancy (MTP). Patients either want the doctors to take decisions that are best for their health, or they want doctors to give them information so that they can themselves take decisions related to their reproductive health. Once the decision is taken, they want information and guidance. More important, they need advice that is practical and relevant to their socio-economic realities, and information they can understand with their limited education.

Health care providers find it difficult to meet all these information needs due to barriers related to language, culture and class differences, lack of appreciation of the socio-economic realities, and gender factors that have led to a woman's decision.

Other communication barriers include lack of resources in the OPD (which hampers quality of care), privacy, limited time and lack of patience with the patients. Health care providers are generally trained only to focus on the bio-medical aspects of health, ignoring the socio-economic and cultural factors that determine health status and treatment seeking. This limits their view of gynaecological patients as reproductive organs rather than seeing them as a whole – as women and human beings. In the existing culture of silence and shame related to reproductive issues, women are considered as mere producers of children having little say in decisions related to their marriage, sexual relationship in marriage, how many children to have and when to have them. In spite of these ground realities, it is women who are made the targets for family planning programmes or are held responsible for their husbands' irresponsible sexual behaviour.

A qualitative study carried out by WCHP on the communication between health care providers and patients in the Gynaecology OPD of a secondary peripheral hospital using the participant observation technique¹ showed that health providers lacked sensitivity and did not understand the background and context against which women express their needs and choices. This is illustrated in several case studies observed during the study (the case studies are presented in Handout 8.9).

¹ The project had undertaken a study on observing communication between the health care providers and the patients in the Gynaecology OPD in a secondary peripheral hospital. The observer hung around the OPD, during the consultation, followed patients outside the OPD and noted the interaction between the doctor and the patient, verbatim. Eighty episodes of interactions between the doctors and the patients were observed and recorded over 15 days during this exercise.

The health providers imposed their views on what is best for the women, ignoring the fact that these women had really very little freedom to decide whether or how many children they wanted. Thus, sometimes target-oriented policies make the providers insensitive to women's needs, leading to delayed treatment and further health complications.

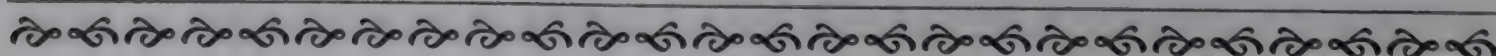
Women are afraid of treatments that require major invasive procedures. It is therefore essential that the health providers also prepare these women by giving them detailed information about the procedures that they are about to undergo. Often health providers ignore patients' need for information to allay their fears.

Sometimes barriers like language and educational attainment affect the history-taking process and the doctors fail to understand what the woman is trying to communicate and vice-versa. Such women need more patient and sensitive handling.

The case studies show that Health care providers need to be informed on how gender, social and cultural factors affect women's lives. They need to know the woman's background and the social and cultural burdens she carries with her apart from presenting with physical problems, since all these factors are also likely to affect her ability to follow the treatment and the advice given by the doctor. Health care providers thus need to be aware and sensitive about the socio-economic factors, gender issues, and also use appropriate communication skills to help patients make informed decisions.

It is also evident that the counselling would depend mainly on different aspects of the patient's gynaecological condition. Thus the counsellor takes into account the following factors for any gynaecological condition before deciding on the course of intervention in a counselling session.

1. Specific condition or problem that the woman has
2. Discomfort caused by it and the woman's other experiences related to this condition
3. Socio-economic realities of the woman
4. Information she already has on her condition and her need for more information
5. The woman's perception of the treatment that she feels is best for her
6. Ability to articulate her problems and assert her needs
7. Freedom to make a choice and decide to follow the medical advice
8. A woman's right over her reproductive organs and health
9. Ability to convince her partner/other decision makers in the family to support her in the decision that she has made along with the doctor.



Studies done by WCHP revealed that women's expectations from the health care providers in the gynaecological OPD were:

History-Taking

- Someone to listen to her problems sympathetically and completely
- Help her to clarify and specify the symptoms as accurately as possible
- Help her to articulate the facts related to her history
- Ensure privacy for talking about sensitive issues like sexual practices
- Listen without labelling or making judgments on her life style
- Believe in her experiences of the symptoms

Preparing for internal examination

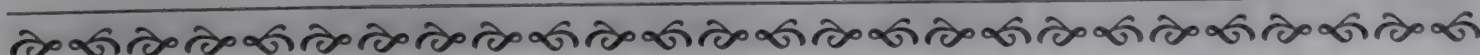
- Telling her why the internal examination is done, how it is done
- Reducing her fear and shame by providing privacy for removing her clothes
- Instructing her clearly on how to position herself
- Inform her about the findings

Investigations

- Giving instructions clearly and in simple language
- Explaining why, where, when, cost and so on regarding the investigative procedures
- Explain the preparatory requirements, for example, coming on an empty stomach or after how many days of the menses
- Communicating the diagnosis or the findings

Treatment and follow-up

- Clear instructions to follow the advice
- Follow-up date and assurance that she can come any time in case of complications or severity of the symptoms
- Advice on sexual aspects of the relationship to the husband
- Help to take decisions regarding use of family planning methods or surgeries that are best suited in her case
- Give after-care instructions that are practical
- Reassurance that she will be all right



Prevention

- Preventive instructions
- Information related to causes, treatment options

Referral

- Clear instructions about where to go, location of the referral centre, timings, and cost involved etc.

To fulfil the expectations of the patients, the health care providers need to have patience, caring and non-judgmental attitude, understanding about unequal gender relations, socio-economic cultural factors affecting women's reproductive and sexual health, and general counselling and communication skills.

Training sessions related to sensitive gynaecological counselling are included in the following module.

Module Objectives

This section of the manual includes training sessions for counselling based on information needs of women related to specific gynaecological conditions. We have also given the general steps that the counsellor can follow during the counselling or information session for any condition that the patient approaches him/her.

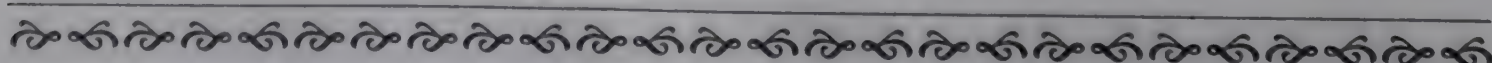
This section includes sessions that will address the needs of patients according to the conditions that are commonly seen in the OPD and the checklist that can be followed for each of these conditions. The checklist for infertility is included in Annexure 8. 1 as an example.

At the end of this module the participants will be able to

- Identify gender issues in reproductive health conditions
- Follow the steps in the sensitive consultation and communication process for several gynaecological conditions.
- Guide and help the patient to her satisfaction

Some sessions in this section can be clubbed with sessions from the section on Communication and Counselling Skills. The session outlines are divided into different phases of the consultation process, for example, History Taking, Internal Examination, Investigations, Treatment and Follow-up, Referral etc.

Many of the sessions in this module are designed to include actual visits to the OPD and observing and talking to women. One should be careful to follow ethical principles and take permission or consent from the women and health care providers wherever there is an interaction in terms of observation or actual interviewing. If such permissions or consent are not given, the sessions should be conducted in the classroom with case studies and OPD episodes available in this module.



Session 1 Gender Perspective in Reproductive Health

Learning Objectives

- At the end of the session participants will
- describe differences between 'sex' and 'gender'.
 - state how gender affects aspects of reproductive health.

Resources

- OHT 8.1 Pictures of gender stereotypes on transparencies
- OHT 8.2 Sex and gender, characteristics of gender
- OHT 8.3 Gender as a System
- OHT 8.4 Gender Issues in Pregnancy
- Handout 8.1 Gender issues in Reproductive Health
- Handouts of gender stereotype pictures- 1 to 2 sheets per group
- Papers and marker pens.

Time 2 hours

Methodology

- Participants are divided into four buzz groups.
- Each group is given the 2 sheets of pictures, and they are asked to identify the sex of the person in the picture after discussing among themselves. They also have to state the reasons why they say the picture is of a man or a woman. (15 minutes)
- Facilitator then asks each group to share their views. The reasons for their choice are listed on the board. (15 minutes).
- Through summarising these reasons the facilitator helps participants to distinguish between SEX and GENDER with help of OHT 8.2 (10 minutes).
- Facilitator explains GENDER AS A SYSTEM with the help of OHT 8.3 (10 minutes).
- The facilitator shows gender analysis of one reproductive health issue – e.g. pregnancy - using OHT 8.4. (10 minutes).
- Participants are then divided into three groups. Each group is asked to analyse one reproductive health issue from the gender perspective. The RH issues can be RTIs/ STIs, Infertility, MTP. They are asked to write their analysis either on a transparency or on chart paper (30 minutes).
- Each group then makes a presentation (25 minutes).
- Facilitator adds the points if missed by the group, and summarises the session on the basis of Handout 8.1.

Facilitator's Note

Gender is a challenging concept for male participants. Many will resist accepting that women are not subordinate and discriminated against. Point out that gender construction does not allow even men to be themselves, to be humans. Men are also victims of patriarchy and gender, although to a much lesser extent than women.

Further Sessions

The following sessions will enable participants to enhance their skills related to all stages of the Consultation Process - History Taking, Internal Examination, Investigation, Instruction for Treatment and Follow up, Contraception Counselling and Referrals.

The sessions in this section are numbered accordingly

A. History-Taking

This topic is an example of the application of interviewing skills described in the communication and counselling chapter.

Session A1 Use of Open-Ended and Probing Questions

Learning Objectives

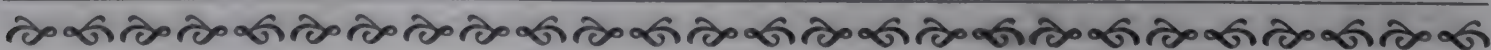
- At the end of the session participants will be able to
- convert the close ended questions into open and probing questions
 - use the different types of questions effectively to elicit information from the patient

Time 60 minutes

Resources Examples of questions of each type written on OHT 8.5.
Copies of list of different types of questions, (Handout 8.2).

Methodology

1. Facilitator explains each type of question with the help of examples put up on the OHT 8.1.
Participants are then given the list of different types of questions (Handout 8.2) – closed, open-ended, judgmental, leading questions - and are asked to classify the questions into different types.
2. Facilitator then asks the participants to convert some close-ended questions into open ended questions and initiates a discussion on the type of questions to be used at different times during the interview process.



Points to Emphasise

- The type of questions one asks often determines the quality of information that one gets
- To get detailed responses, we need to use open-ended or probing questions.

Session A 2 Practicing the Skills of History-Taking

Learning Objectives

- At the end of the session participants will be able to
- elicit the history of the patient in a sensitive and effective way

Time 2 hours

Resources

Copies of the case studies – Handout 8.3, checklist for monitoring consultation on different conditions (Handout 8.4, 6.8), OHT- 8.6 with the main points of effective history-taking.

Methodology

1. Participants are divided into three groups. Each group is given a case study; they plan a role-play of the history-taking session on the given condition in the case study. (20 minutes)

Case 1

A woman investigated for leucorrhoea comes with her investigation report. Her report shows presence of gonococci. The woman is illiterate and has four children. Her husband is a construction worker and stays away from home for several days at a stretch. She does not know if her husband has any health problem. The doctor has sent the case to you asking you to ask her husband to come for a check-up.

Case 2

A woman married for 6 years has been unable to conceive. She is 28 years old. Her husband is working in an office as a manager while she is a school teacher. Her family members are constantly abusing her. She had one MTP 5 years ago. She starts crying and tells the doctor that she wants to have a child soon or her in-laws will send her away to her mother's place. The doctor asks her to get the necessary investigations done and sends this case to you for counselling.

Case 3

A 26-year-old woman wants TL. She has a 5-year-old son, who goes to pre-primary school. Her husband is 30 years old. She has been advised by the doctors to wait for a few years to conceive her second child. The doctors have also suggested copper-T. But the woman is firm on her decision. She wants TL.

2. Each group presents the role-play and the other participants observe it. After each role-play the participants and the facilitator fill the checklist and give feedback to the presenting group. (15 minutes per group)
3. Facilitator then summarises the feedback and revises the main points in Effective History-taking with the help of a transparency or flip chart.

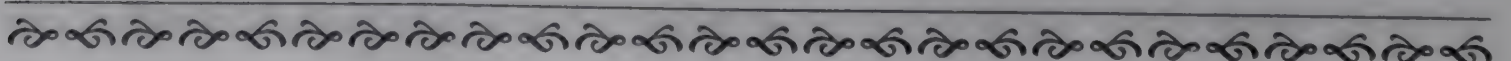
Facilitator's Note

The facilitator should emphasise that the point of the role-plays is not to demonstrate what good actors we are, but to demonstrate principles of sensitive and effective history-taking.

The facilitator will have to be strict about time. Each role-play should be about 8 minutes and the feedback should be given in the remaining 7 minutes. The facilitator should highlight principles of woman centred counselling

Points to Emphasise

- Be aware of, and sensitive to, the needs of women.
- Provide privacy — visual and audio
- Establish rapport — making the patient comfortable
 - Make her sit down
 - Be respectful
 - Maintain eye contact
 - Ask simple questions in the beginning
 - Be patient
- Ask open-ended questions
- Avoid leading and judgmental questions
- Use local terminology
- Use knowledge of local cultural festivals to determine the onset of a problem,
- Believe in women
- Get correct obstetric history – use a sympathetic and gentle tone and avoid judgements
- Sexual history – Are you comfortable talking about sexuality?



Session A3 Applying the Skills of History-Taking

Learning Objectives

At the end of the session participants will be able to

- state the principles of taking history of patients in a sensitive and effective way
- demonstrate the importance of the social history for a gynaecological consultation

Time 1 hour

Resources

Copies of format for history-taking (Handout 8.5)

Permission to talk to the patient in the waiting line in the Gynaecological OPD, and follow them during consultation.

Methodology

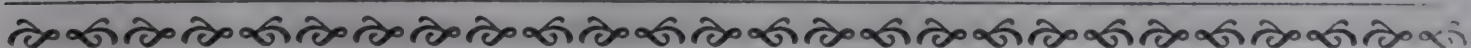
1. Participants are asked to go to the Gynaecological OPD. Each participant talks to a woman (after taking her consent and explaining the purpose of the exercise) waiting outside the OPD.
2. Each participant tries to gather all the relevant social facts related to the woman's condition and write these down in his/her notebook or on the format given to record the social history of the patient.
3. They stay with the woman in the OPD, observe her interaction with the doctor and see whether the social facts they gathered have any significance on the outcome of the consultation in terms of decisions related to use of family planning methods, or surgeries that the doctor advises. (30 minutes)
4. Participants come back to the classroom, share their experiences of the history taking and the consultation process observed. (25 minutes)
5. Facilitator summarises the discussion. (5 minutes)

Facilitator's Note

- Facilitator discusses and ensures that the participants understand the importance of 'taking consent' before talking to women in the OPD.
- Also facilitator draws out socio-cultural and gender-related issues from the sharing of the participants and helps them reflect on these.

Points to Emphasise

- Gynaecological problems and their implications for women are not only physical or physiological but are related to her socio-economic and cultural conditions, status of women in the family, and gender dynamics operating in the family and the society.



B. Internal Examination

Session B1 Sensitivity during Internal Examination

Learning Objectives

- At the end of the session participants will
- understand, to some extent, and have an increased sensitivity towards the feelings of shame/fear, associated with the process of internal examination
 - list down the do's and don'ts of internal examination

Time 45 minutes

Resources Flip chart and a marker

Methodology

1. Women participants are asked to share their first experience of internal examination.
 - When was it done, at what age, before or after marriage
 - Why they had to do it
 - Which clinic (private or public sector)
 - Whether male or female doctor
 - How did they feel about it
 - What would have made them feel better, more comfortable
2. Facilitator writes on the board the factors that made the participants feel better or uncomfortable during the internal examination (30 minutes)
3. From this list the do's and dont's during the internal examination are drawn out. (15 minutes)

Points to Emphasise

SAMPLE OF DO'S AND DONT'S

Do's

- Be sensitive to women's shyness and fear
- Be respectful, gentle and caring
- Reduce fear and shyness
 - Explain what examination is going to be done and why
 - Give her sufficient time to prepare herself mentally and physically
 - Take her consent before examination.
 - Provide visual and audio (if possible) privacy
 - Provide a sheet to cover her body.
 - If a male doctor is going to examine her, tell her before the examination

- Give proper instructions
 - Ask whether she is menstruating before the examination
 - Ask her to pass urine before you do an internal examination.
 - Explain that she needs to loosen or untie her garment or remove her underclothes.
 - Instruct about proper position
- Allow her to hold the attendant's hand, if she feels some pain during examination.
- Explain the findings without scaring or humiliating her.

Don'ts

- Do not yell, shout, talk with disrespect
- Do not hit her on the legs as a way of directing her to take a proper position.
- Do not express shock about findings. Do not exclaim, "Oh, my god !" , "Look at this", "Oh, it is so bad" , "Yeh Kya Kiya hai?," etc.
- If a child or a person who has never had intercourse no vaginal examination should be done. Only rectal examination should be carried out.
- Do not think of the woman's expression of pain as fuss and neglect it.

Session B2 Instructions during Internal Examination

Learning Objectives

At the end of the session participants will

- know the instructions that have to be given during internal examination that will make the patient feel comfortable.

Time 1 hour

Resources

Checklist for observing internal examination (Handout 8.6),

Permission to observe the internal examination process in the OPD.

Methodology

1. Participants are asked to go to the OPD and observe the internal examination process for a few patients after getting consent. The participants note down the instructions given by doctors or nurses to the patient (Handout 8.6). Also note down the positive features and the negative features (refer to list of do's and don'ts) and their effect on the patient and the patient's response to the examination (20 minutes).
2. They come back and discuss their observations. (20 minutes)
3. Participants are then asked to prepare a poster of instructions that can be put up in the OPD for the patients and the doctors to see. (20 minutes)



Facilitator's Note

The facilitator can arrange for the participants to go back to the OPD the next day, to demonstrate how to give instructions to the patient. Each participant gives instructions to at least one woman before they are asked to go for the internal examination.

Points to Emphasise

If the doctors and nurses communicate in a gentle, respectful, sensitive way with the patient, the other staff members present will also follow the role model. The clinician and the nurse have great responsibility in establishing a role model for responsible and respectable behaviour towards the patient.

C. Investigations

Session C1 Knowing about Investigations required for different Gynaecological Conditions

Learning Objectives

At the end of the session participants will

- know the investigations that are generally required for common gynaecological conditions, their need, use, how and where they are done, cost involved, and so on.

Time 1 hour

Resources

A medical doctor (preferably Gynaecologist) as a resource person.
List of conditions and investigations required to be done for each of the conditions (OHT 8.7)
Handout 8.7 (A), 8.7 (B), Samples of filled-in case papers.
Annexure 8.1 Poster on Investigations.

Methodology

1. The resource person explains the various investigations that are generally done for certain Gynaecological conditions using OHT 8.7. (20 minutes)
2. The resource person also explains the short forms that clinicians use to indicate the investigations on the case papers. (10 minutes)
3. Participants are then given copies of case papers and they interpret the short forms and prepare instructions that need to be given to the patient. (15 minutes)
4. Participants present the instructions and the resource person gives them the feedback. (15 minutes)
5. Facilitator ends by referring to Annexure 8.1 which shows a poster on investigations to be displayed in the OPD.

Facilitator's Note

- Facilitator discusses the importance of the counsellor knowing the investigations for all the conditions.

Points to Emphasise

- Most commonly asked questions and doubts by the patients are related to, what, where and cost of the investigations
- It is important for a counsellor to know the terms and short forms used by the doctors for the investigations advised so that they can answer patient's questions.
- Keeping a list of all the investigations required for different conditions would be helpful in the counselling process.

Session C2 Guiding patients to various departments in the hospital for Investigations

Learning Objectives

At the end of the session participants will

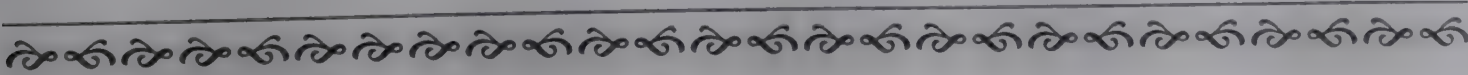
- know all the departments to which gynaecological OPD patients are referred to for investigations.

Time 1 hour

Resources Notebook and Pen, permission to visit all the departments, and appointments at the departments.

Methodology

1. The participants are asked to play the role of patients and go to various departments in the hospital. They are given following instructions:
 - Do not say or show that you are a staff member
 - Register yourself at the case paper counter as a gynaecological patient
 - Go to a doctor in the gynaecological OPD and ask him/her to write one or two investigations to be done for training purposes
 - Go to the particular departments and ask for information on when, where, how the investigation is done, when patients can come for actual tests (generally appointments for tests are given after two days). (30 minutes)
2. The participants come back to the classroom and share the information and their experiences.
3. The problems and their probable solutions are discussed. (20 minutes)



- 4. Participants in small groups make
 - a poster on all the information related to various investigations and display it in the OPD. (See annexure 8.2 for the sample)
- 5. The participants display their work in the larger group.

Facilitator's Note

If it is not possible for the participants to act as patients for ethical reasons, they can be told to go as trainees and talk to the providers in each department and gather the information.

Points to Emphasise

- If women understand why and what needs to be done, they will be motivated to follow the instructions and get the investigations done.
- If explanations are not clearly given, women do not understand, and feel that the doctor is just sending them here and there. They may get fed up and may leave the treatment or investigations half-way.
- If we want the patient to co-operate and participate in the treatment process it is important to explain the results of the investigations in simple language.

D. Instructions on Treatment and Follow-up

Session D1 Clarity in Communication Regarding Information given to the Patient

Learning Objectives

At the end of the session participants will

- state the reasons for giving clear instructions to the patients regarding treatment and follow-up.

Time 1 hour

Resources Permission to observe interactions in the OPD
Checklist to observe instructions and information regarding treatment and follow-up (Handout 8.8)
OHT 8.8 Instructions on treatment and follow-up

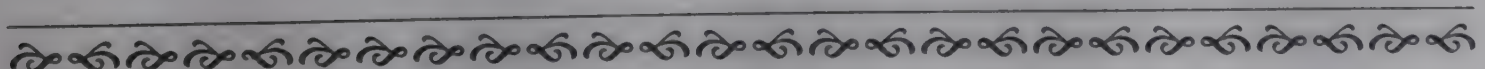
Methodology

- 1. Each participant is asked to imagine that they are suffering from a particular gynaecological condition. They are asked to write down what they would like to know about their problem during the doctor's consultation (5 minutes)

2. These points are listed on the blackboard. These should look something like contents of Handout 8.9. (10 minutes)
3. Participants go to the Gynaecology OPD and observe the interaction between the doctors and the patients before the patient leaves the OPD. The checklist derived in the classroom or Handout 8.8 is used to observe this interaction. They also note the points that could have been included in the information given by the doctor. (20 minutes)
4. Participants come back to the classroom, share their observations. (15 minutes)
5. Points that need to be included in the information given to the patient before the patient leaves the OPD are listed out of the sharings. (10 minutes)
6. Facilitator generates “reasons for failure of follow-up”, from experiences of trainees, and discusses do's and don'ts in giving information related to treatment and follow-up, with the help of transparency (OHT- 8.8)

Points to Emphasise

- Women will feel motivated to follow the advice given by the providers if the providers exhibit and express genuine concern for women's health
- Women, and especially sick women, perceive doctors to be very powerful figures. As a result, they become powerless and lose their confidence in the presence of doctors. It is important for doctors and other health care providers to be conscious of this and try to infuse their patients with confidence by listening patiently, encouraging women to ask questions, and providing information that will help them to take informed decisions.
- Women may have genuine problems to come for a follow-up. Explore the reasons first rather than assuming that women are careless about their health. Once the reason for a woman's failure to come for follow up is understood, one can attempt to resolve and deal with the situation accordingly. Encourage her to come for regular follow ups by suggesting solutions to her problems.
- After helping her to deal with her problems, if she repeatedly fails to come for follow up, one can firmly explain to her what would be the results of non-compliance and irregular treatment. Importance of follow-up can be stressed.



E. Contraception Counselling

Session E1 Understanding ‘Personal Is Political’ - Sharing personal experiences of using Family Planning methods

Learning Objectives

- At the end of the session participants will be able to
- state problems and concerns of women related to various contraceptive methods.
 - recognise the universal nature of women’s experiences in relation to contraceptives. (Experiences of women from different backgrounds like class, education, caste, religion related to the contraception could be similar).
 - realise that being health workers does not mean that they are different ‘as women’ from other women, or that “other women” can also have the same problems as them and hence learn to empathise with the community women.

Time 90 minutes

Resources Black board and chalk, OHT 8.9.

Methodology

1. Participants are asked to pair up with the person sitting next to them. They share with each other: (20 minutes)
 - Whether they have ever used any contraceptive methods
 - Which method, why did they choose a particular method, who took the decision
 - How long did they use it
 - What were the reactions of the family members
 - Whether they had any problems with the method
 - Each pair shares their experiences within the larger group
2. Facilitator lists the methods used, and the problems they had with the method, on the board (20 minutes)
3. Facilitator draws attention to the fact that women in the community also go through the same experiences, and hence as women health workers we need to be sensitive to other women’s problems. (5 minutes)
4. Facilitator presents the OHT 8.9 on Reproductive Rights and discusses these in the context of contraceptive methods. (20 minutes)
5. Facilitator asks participants to remember the principles of Woman Centred Counselling in the context of contraception methods (refer to OHT 6.10) (15 minutes)

Facilitator's Note

- Men in the group can be paired with men.

Points to Emphasise

- For woman-centred counselling, the health workers should first reach out to clients as 'women', create a sense of trust and sisterhood, so that the client will share full and correct information, articulate problems and other relevant details.
- Time and space could be created for the client to feel strong and capable to take decisions by giving her time to think, and return when she is ready.

Session E 2 Reproductive Rights

Learning Objectives

At the end of the session participants will be able to

- state reproductive rights of the clients visiting gynaecological OPD
- reflect on whether women's reproductive rights are upheld in the current set-up of the health post or gynaecology OPD at the general hospital
- reflect on barriers to uphold Reproductive Rights and suggest ways to overcome them.

Time 90 minutes

Resources Black-board, chalk, OHT 8.9 on Reproductive Rights, Episodes from the OPD-Handout 8.9, Handout 8.10 on Reproductive Rights, Transparencies on Woman Centred Contraception Counselling (OHT 8.10).

Methodology

1. Ask the participants to list one expectation from a gynaecologist or a doctor or a health centre related to contraceptive services which would satisfy them or make them feel good about the service or the centre.
2. Facilitator lists the expectations on the board. These expectations are then classified as related to technical competence, choice of method, information and interpersonal relations, continuity of service, integrated services.
3. Facilitator then shows the transparency on reproductive rights (OHT 8.9)
4. Participants are then divided into groups of 3-4 and each group is given two recorded episodes from the OPD. They have to read the episode to the group and discuss the following points and write them on transparencies.
 - i. Which rights are violated or ensured?
 - ii. What are the barriers to ensure these rights?
 - iii. Suggestions to overcome barriers and ensure rights?

5. Participants present the discussion to the larger group with the help of the transparencies.
6. Facilitator summarises the session with the help of OHT 8.10 on Woman Centred Contraception Counselling. (OHT 8.10)

Facilitator's Note

Facilitator can highlight the fact that the barriers to ensure reproductive rights could be

- Policy/Programme related
- Logistical problems
- Personnel problems

A lot can be achieved by trying to overcome the personnel and logistic related problems to ensure Reproductive Rights within the constraints related to population policies and resources.

Session E3 Technical information on contraception methods

Learning Objectives

At the end of the session participants will be able to

- state when each method can be advised, how it works, contra-indications.\

Time 2 hours

Resources

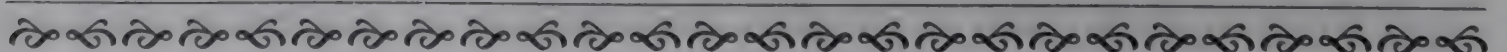
A medical doctor and a contraceptives counsellor as resource persons

Samples of all the contraceptive devices available in the market

OHT 8.11 on Contraceptive Counselling

Methodology

1. Participants are asked to write down their questions related to the contraceptives. They are also asked to include the questions generally asked by women in the community, their concerns and fears about various contraceptives. (10 minutes)
2. The questions are then given to the resource person. Resource person conducts a technical session on different contraceptives with the help of the Handout 8.12. (45 minutes)



Session E4 Counselling Women on use of contraceptives

Learning Objectives

- At the end of the session participants will be able to
- state how to counsel a woman on contraception issues from the gender and rights perspective.
 - demonstrate the use of the cafeteria approach

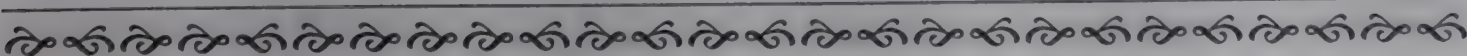
Time 3 hours

Resources

A contraception counsellor as resource person
Copies of the “Protocol for Contraception Advice”,
Handout 6.8 (refer to Handout 6.8 in chapter 6 on Communication and Counselling)
Role-play situations – Handout 8.11
IEC Pamphlets on Contraceptive Methods (not contained in this manual).

Methodology

1. Participants are divided into two groups. Group A participants are asked to form 3 subgroups and each group is given a role-play situation from Handout 8.11 to demonstrate the effective counselling technique for contraceptive use. They are encouraged to use the IEC pamphlets as a part of their counselling. They are asked to go to another room to plan their role plays. (30 minutes)
2. The facilitator also joins the group and guides them on how to demonstrate the rights perspective, and the cafeteria approach
3. Participants of group B discuss the “Protocol for Contraceptive Advice”, Handout 6.8, while group A prepare role-plays.
4. Each of the 3 subgroups performs a role play, and the other participants, including the facilitator, observe them using the Contraceptive Protocol and Checklists (30 minutes- 10 minutes each)
5. Feedback is given to each group after their presentation (15 minutes)
6. Common mistakes, or don'ts and do's, are listed on the board and are revised at the end of the session (5 minutes)
7. The participants then go to the OPD or wards to talk to women who are users of any contraceptive method, after obtaining consent from the women. They are asked to find out how and why did the woman choose a particular method, her experience with that method. (30 minutes)
8. Participants then share the womens' stories in the classroom. (45 minutes)



9. Common points are then drawn out on the decision-making process, problems with a particular method as well as positive experiences of the women, once again from the Reproductive Rights framework. (15 minutes)

Facilitator's Note

- The men trainees can talk to the men who are waiting outside the PNC ward, or accompanying a woman for the ANC check-up, or men awaiting outside the gynaecology OPD whose wives are in the ward.
- The feedback to the participants should be related to the reproductive rights discussed in the earlier session.

Points to Emphasise

Based on the actual experiences of women, a discussion is held on the gaps between what should happen and what happens in reality. And hence it is necessary to understand that the same or 'one package of advice' does not suit everybody. Contraceptive counselling has to differ from person to person, based on the needs of that person, man or woman.

F. Referral

Session F1 Referral Centres for Gynaecological OPD

Learning Objectives

At the end of the session participants will be able to

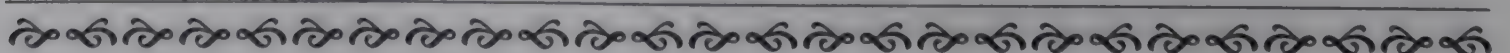
- state names of referral centres around the hospital and their location, timings, procedures for investigations, cost of travelling to the referral centre and cost of the services offered at the centre

Time 90 minutes

Resources List of referral centres around the hospital, OHT 8.11 – referral guidelines.

Methodology

1. Participants form pairs and visit one centre each. They are given following instructions
 - Pretend that you are a patient
 - Visit the centre and find out all the details about different tests and investigations, by interacting with the staff at the centre (45 minutes)
2. They come back to the classroom and share their findings and experiences
3. A list is made of all the centres visited and the details about each centre in terms of location, timings, etc. (45 minutes)
4. Facilitator summarises using OHT 8.11.



Facilitator's Note

Choose referral centres to which women are most commonly referred e.g. sonography centre, shelter home for battered women and 'unwed mothers', adoption counselling services.

G. Preventive Information

Preventive information is an important part of the consultation process. Often health care providers find it difficult to explain the necessary technical details to non-literate patients because of language barriers and lack of time. Use of IEC material to explain facts, can ease this difficult task for the health care providers.

Session on effective use of IEC material for giving information to the patients is included in the previous section on communication skills.

Session G1 Practical experience of working with clients visiting the Gynaecology OPD

Learning Objectives

- At the end of this session participants will be able to
- identify needs to talk to women in the gynaecological OPD
 - introduce themselves to clients and build rapport with them
 - demonstrate sensitivity and empathy towards the emotional and informational needs of the client (new and follow-up cases)
 - demonstrate sensitivity towards women undergoing P. V. Examination
 - know how to approach and talk to men accompanying women in the OPD
 - know the locations of different investigation departments, procedures and cost of all the investigations carried out in the hospital
 - build rapport with referral centres and know the referral procedure

Time 3 hours, 30 minutes

Resources Appointments and consent of the hospital staff and administrators for the field visits

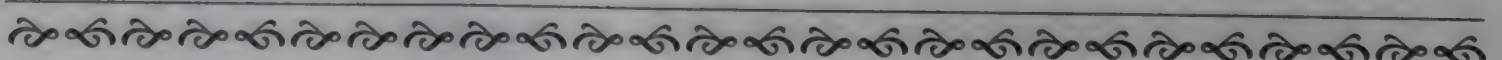
Methodology

1. Participants are divided into pairs and each pair is asked to visit the different departments in the hospital like gynaecology OPD, labour ward, gynaecology ward, VCTC (AIDS counselling centre) and a referral centre for 'unwed mothers', women facing domestic violence, an adoption centre, around the hospital.

2. Discussion is held on the essentials of rapport building and talking to clients—like introducing oneself, consent of the client, ensuring privacy and confidentiality
3. Participants are given following tasks
 - Speaking to a client outside gynaecology OPD who has a new case-paper.
 - Speaking to a client outside gynaecology OPD who has come for a follow-up.
 - Observing the intern of the gynaecology OPD during history-taking from the client.
 - Observing the doctor of the gynaecology OPD doing a PV examination.
 - Speaking to a PNC client in the labour ward.
 - Speaking to a client in the gynaecology ward.
 - Observing VCTC counsellor during counselling.
 - Speaking to spouse/relative of the client outside the gynaecology OPD.
 - Speaking to spouse/relative of the client outside the labour ward.
 - Find out the location, timings, procedures for various investigations done in the hospital.
 - Visit to a temporary shelter home for unwed mothers to gain an insight about their functioning procedure.
4. Participants write about their field visit experience and make a presentation to the larger group.
5. Participants are asked their feelings regarding the experience and comments from all the participants are invited after each presentation.
6. Essentials and importance of sensitive gynaecological counselling are discussed at the end.

References

1. **Improving provider-client communication style in selected health facilities of Brihanmumbai Municipal Corporation**, by Swati Pongurlekar, Renu Khanna, Korrie de Koning, and Nandini Roy. Paper presented at the 5th Asia-Pacific Social Science and Medical Conference, Kandy, Sri Lanka September 24-28, 2000.



HANDOUT 8.1

REPRODUCTIVE HEALTH (RH) IN INDIA : A GENDER AND RIGHTS ISSUE

What is Gender?

Gender is the socially created differences between women and men.

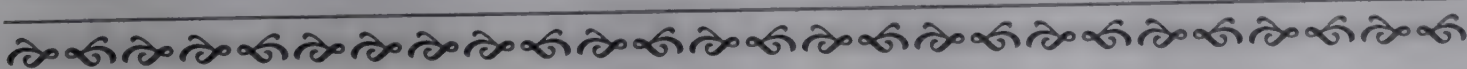
- It is not natural or biological
- It is different at different places and times
- It changes and can be changed (though not easily)
- It is hierarchical

Gender Differences

Aspect	Women	Men
Roles and responsibilities	Work at home Look after children Look after the sick	Go out to work for money Cannot be expected to cook or clean
Access and control over resources	Does not own or inherit property No choice regarding having sex/child Time of having child is decided by others	Property is in his name/inherits property More educational opportunities Entitled to leisure
Behavioural stereotypes	Weak Emotional Dependant Shy	Strong Rational Independent Tough

Some Gender Differences.....

Life cycle	Differences
Before birth	Sex selective abortion of the female foetus
At birth	Celebrating the birth of a boy.....
In childhood	Differential treatment- food, care in sickness, education, work, play, age at marriage.....
Adult life	Women's mobility restricted, violence, cut off from natal home, limited rights etc.....
Older age	Desertion, lack of physical and emotional security for women.....



Some Important RH concerns in India

- ☐ Unwanted pregnancies
 - Contraception as well as infertility
 - Unsafe abortions; sex selective abortion
 - Maternal morbidity and mortality
 - Cancers
 - Reproductive tract infections, HIV/AIDS
 - Concern for adolescent health

Why is Reproductive Health a gender issue?

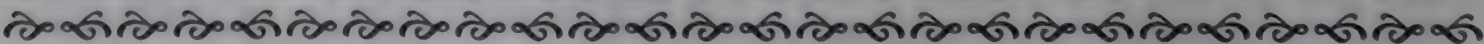
Because most reproductive health problems arise from, or are complicated by, unequal gender relations

Manifestation of Gender and Rights violations in RH issues

- At the level of cause
- At the level of the individual's own response
- At the level of family response to the situation
- At the level of the treatment – accessibility and availability of treatment as well as the attitude and behaviour of the provider

Gender dimension and Rights violations: Anaemia in Pregnancy

Aspect	Gender and Rights Dimension
Causes	Dietary customs; workload; repeated pregnancies/abortions etc.
Response of the family	Accused of malingering; no sharing of workload; no treatment
Response of the individual	Self-blame; works hard despite weakness
Response of the provider	Not available; Blames her for not seeking help in time



Gender dimension and Rights violations: Unwanted Pregnancy

Aspect	Gender Dimension
Causes	No control over sexual negotiation; lack of contraceptive knowledge, violence
Response of the family	Accused of bringing dishonour to family; sex-determination tests
Response of the individual	Self blame, resignation, suicide
Response of the provider	Blames, ridicules, no respect for privacy/ confidentiality, extortion

Gender dimension and Rights violations : RTIs/STIs

Aspect	Gender Dimension
Causes	No power of sexual negotiation, no knowledge about own body, violence
Response of the family	Husband doesn't take responsibility, stigma, no treatment
Response of the individual	Shame, inability to disclose, suffering in silence
Response of the provider	Male provider—lack of knowledge, insensitivity, stigma

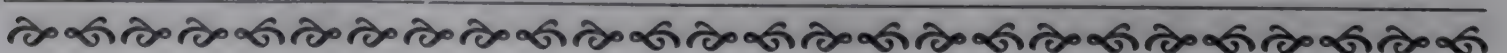
RH and Gender - No compromises

It is not possible to deal with Reproductive Health Issues and Problems of the people, especially of women, until we acknowledge and deal with the gender-based discrimination and violence which gives rise to, or aggravates these conditions.

HANDOUT 8.2

TYPES OF QUESTIONS

1. Are you married? _____
2. What do you think about limiting your family? _____
3. What do you think is good about breast milk? _____
4. How do you feel about the treatment in the hospital? _____
5. How many years ago did you get married? _____
6. What other medicines or treatment did you take? _____
7. What is the colour of your discharge? _____
8. You had heavy bleeding when using copper T. Can you tell me a bit more about what happened? _____
9. Do you have any other problem? _____
10. Did you decide on the number of children you want to have? _____
11. Is it good to space children? _____
12. Do you think inserting Cu-T soon after MTP has caused you problems? _____
13. You said that you felt giddy after the pills that your family gave you.
For what were the pills given? _____
14. Do you get thin discharge? Is it yellow in colour? _____
15. Do you have pain during intercourse? _____
16. Did you take oral contraceptive pills to regulate your period? _____
17. You said that you have discharge. How is the discharge?
Does it smell? What does it smell like? _____
18. Many women feel shy to talk about their genital infections.
What do you feel about it? _____
19. You are not married and you missed your period? _____



HANDOUT 8.3

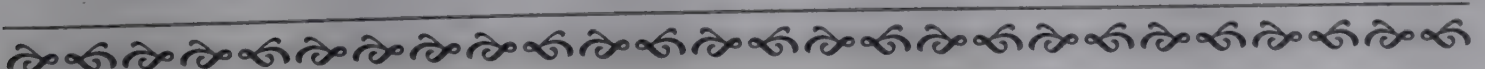
CASE STUDIES FOR HISTORY-TAKING

Case 1: A woman investigated for leucorrhoea comes with her investigation report. Her report shows presence of gonococci. The woman is illiterate and has four children. Her husband is a construction worker and stays away from home for days together. She does not know if her husband has any health problem. Doctor has sent the case to you asking you to tell her husband to come for a check-up.

Case 2: A woman married since 6 years has been unable to conceive. She is 28 years old. Her husband is working in an office as a manager while she is a school teacher. Her family members are constantly abusing her. She had one MTP 5 years ago. She starts crying and tells the doctor that she wants to have a child soon or her in-laws will send her away to her mother's place. Doctor asks her to get the necessary investigations done and sends this case to you for counselling.

Case 3: A 26 year old woman wants TL. She has a 5 year old son, who goes to pre-primary school. Her husband is 30 years old. She has been advised by the doctors to wait for a few years to conceive her second child. The doctors have also suggested copper-T. But the woman is firm in her decision. She wants TL.

(TL - Tubal Ligation, MTP - Medical Termination of Pregnancy)



HANDOUT 8.4

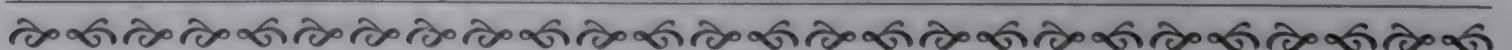
OBSERVATION CHECKLIST FOR MONITORING COUNSELLING FOR MENSTRUAL DISORDERS

Name of the observer : _____ Client number : _____

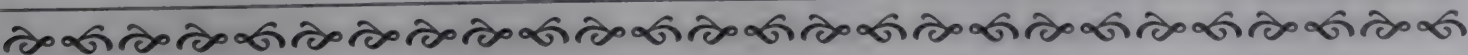
Date : _____ Time : _____

For each question, please circle the appropriate option

1. Assuring confidentiality: Did the counsellor					
1.1	tell the client that the discussion in the session will be kept confidential?	1. Yes	2. No	3. Not applicable	4. Do not know
2. Involving accompanying person in the counselling session					
2.1	If the woman was accompanied by a partner/relative, was the accompanying person invited into the counselling centre if the client desired? (together or separately)	1. Yes	2. No	3. Not applicable	4. Do not know
3. Description of the current problem/Exploring facts: Did the counsellor					
3.1	ask the client about her problem in detail, using open-ended questions? (symptoms, since when, details about menstrual cycle, whether taken any treatment before coming to the hospital, any associated probable causes and so on)	1. Yes	2. No	3. Not applicable	4. Do not know
3.2	explore whether the patient has any other psychological or family problems or tension?	1. Yes	2. No	3. Not applicable	4. Do not know
3.3	explore the food habits and diet of the patient?	1. Yes	2. No	3. Not applicable	4. Do not know
3.4	see all reports and papers?	1. Yes	2. No	3. Not applicable	4. Do not know
4. Exploring client's understanding about her problem: Did the counsellor					
4.1	ask the client to explain what she knew about the treatment/investigations advised by the doctor?	1. Yes	2. No	3. Not applicable	4. Do not know
5. Giving Information: Did the counsellor provide information about					
5.1	anatomy and physiology of menstrual cycle?	1. Yes	2. No	3. Not applicable	4. Do not know
5.2	how the brain controls the hormone level which affects the menstrual cycle?	1. Yes	2. No	3. Not applicable	4. Do not know



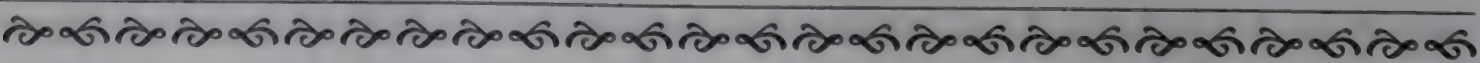
5.3	the probable causes of irregular menstruation?	1. Yes	2. No	3. Not applicable	4. Do not know
5.4	the importance of investigations?	1. Yes	2. No	3. Not applicable	4. Do not know
5.5	the importance of a balanced diet?	1. Yes	2. No	3. Not applicable	4. Do not know
5.6	the importance of completing the course of medicines prescribed?	1. Yes	2. No	3. Not applicable	4. Do not know
5.7	the importance of follow-up visits?	1. Yes	2. No	3. Not applicable	4. Do not know
6. Giving reassurance					
6.1	Did the counsellor reassure the client, telling her that the investigations and treatment may take time and that she should not become impatient?	1. Yes	2. No	3. Not applicable	4. Do not know
7. Information on man's responsibility to the partner: Did the counsellor provide information to the partner regarding:					
7.1	the anatomy and physiology of the menstrual cycle?	1. Yes	2. No	3. Not applicable	4. Do not know
7.2	how the brain controls the hormone levels which affect the menstrual cycle?	1. Yes	2. No	3. Not applicable	4. Do not know
7.3	the probable causes of irregular menstruation?	1. Yes	2. No	3. Not applicable	4. Do not know
7.4	the importance of investigations?	1. Yes	2. No	3. Not applicable	4. Do not know
7.5	the importance of a balanced diet?	1. Yes	2. No	3. Not applicable	4. Do not know
7.6	the importance of completing the course of medicines prescribed?	1. Yes	2. No	3. Not applicable	4. Do not know
7.7	the fact that investigations and treatment may take some time and therefore the need for patience?	1. Yes	2. No	3. Not applicable	4. Do not know
7.8	the importance of follow-up visits?	1. Yes	2. No	3. Not applicable	4. Do not know
8. Encouraging clients to ask questions and share difficulties: Did the counsellor					
8.1	ask if the client had any queries or doubts?	1. Yes	2. No	3. Not applicable	4. Do not know



8.2	answer the questions raised?	1. Yes	2. No	3. Not applicable	4. Do not know
8.3	ask the client if she had any difficulties regarding treatment or investigations?	1. Yes	2. No	3. Not applicable	4. Do not know
8.4	(If the client had any difficulties) discuss the problems and suggest ways of overcoming them?	1. Yes	2. No	3. Not applicable	4. Do not know

9. Confirming whether the information given is understood by the client before she/he leaves:

9.1	Did the counsellor ask the client whether she had any doubts or queries regarding the information given?	1. Yes	2. No	3. Not applicable	4. Do not know
9.2	ask her to repeat the key points of the information provided?	1. Yes	2. No	3. Not applicable	4. Do not know
9.3	ask the client to repeat the date fixed for follow-up visit?	1. Yes	2. No	3. Not applicable	4. Do not know



HANDOUT 8.5

CLIENT CARD

Fact Sheet for Recording Counselling Cases

Date:	Age:	
Name of the Patient:		Centre Sr. No.:
Address: T/P		Husband's/Wife's Sr. No.:
		Code No.:
		Case Paper No.:

Referred By:	Resident of Mumbai	Visiting Mumbai
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Gynaecological History (To be copied from the case paper)

Household / Family Information

Household Size: Earners: Adults: Children:

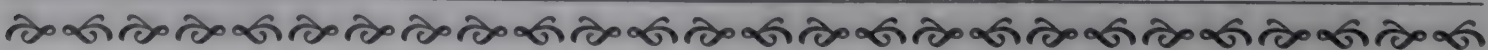
	Age	Education	Occupation	Monthly Income
Patient				
Husband/Father				

NL - Non literate HM - Home Maker UN - Unemployed

HANDOUT 8.6

CHECKLIST FOR OBSERVING INTERNAL EXAMINATION

	Yes	No	N.A.
1. Did the provider explain the procedure of P.V. and what was going to happen to the patient ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Were the following instructions given to the patient before the examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Empty your bladder			
b. Remove your under wear			
c. Please lie down on the table inside the room			
d. Please step on the stool and get onto the examination table			
e. Keep your legs here and move down slowly			
f. Take your clothes up from behind			
g. Bring your waist down			
h. Spread your legs or/and fold them			
3. Did the female Attendant/Nurse giving Gynaec. position explain to the patient politely ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Was the patient made to take the lying position hurriedly ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Was the patient given time to prepare (untying , loosening clothes) for the examination ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Was there privacy during derobing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Were the legs of the patients covered with a sheet during the examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Were the following instructions given during internal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Loosen your tummy			
b. Take a deep breath			
c. Don't get scared			
d. Spread your legs			
9. Were the above instructions given politely?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Was the doctor trying to distract her by talking to her during the examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



11. Was the woman made to get up from the examination table hurriedly?

☐☐☐
12. How much time elapsed between giving position to the woman and doctor's examining her? (minutes)

1

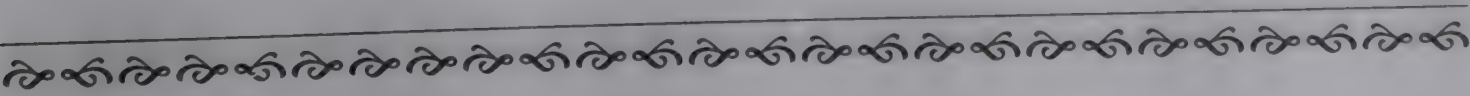
5

10
13. Was P.V. done in a careful, gentle way?
(To be judged from the reactions of the patients).

☐☐☐
14. Was the nurse or attendant present during the examination?

☐☐☐
15. Were the findings of the internal examination explained to the woman ?

☐☐☐



OHT 8.7 (A)

SAMPLE OF CASE PAPER

1. HISTORY C.C.	Age	S. M. W.
H/O amenorrhoea 12 months UOT not done PFI's lactating 5 months she was regularly breast feeding her child until 1 month ago O.P.D. pt willing for MTP only		
2. PAST HISTORY no H/O DM, HT, Jaundice, TB, TB contact		
3. MENSTRUAL HISTORY F. M. P. Regular P.M.C. Moderate L.M.P. 4-5 days 31/7/2004		
4. MARITAL HISTORY M/S 2 yrs		
Sterility	Sexual frequency	
Dyspareunia	Use of contraceptives	
5. OBSTETRIC HISTORY F. T. N. D. Abortions Puerperal infection S1 -> 8 months, FINS Hosp - all over well		
6. PREVIOUS OPERATION no H/O any surgery in the past		
7. VAGINAL DISCHARGE scanty, non foul smelling no H/O any vaginal discharge		
8. BOWELS no H/O any bowel/bladder complaint SIB HS & DR UR		
9. CLINICAL FINDINGS P.A. P.V. - Ga U.I. Fa. P.S. P.R. PR ③ HS on clean		
10. OTHER SYSTEMS UPP +ve Adv UP start		
11. INVESTIGATIONS Vaginal smear Cervical Smear Endometrial biopsy Rubin's test A.Z. Test B.S.R. Blood K.T. Blood sound Urine Seminal fluid Hysterosalpingograph Cystoscopy findings Fluor report		
12. FOLLOW UP		

HANDOUT 8.7 (B)

SAMPLE OF CASE PAPER

1. HISTORY C.C.	Age	B. M. W.
<p>23 yr F. m/s G4 P2 L2 A1 E 2 1/2 MA. for MTP & TL O.P.D. NO PH/O any major medical St illness</p>		
2. PAST HISTORY		
3. MENSTRUAL HISTORY		
F. M. P.	P. M. C.	
P. M. C.	L. M. P.	3/6/04
4. MARITAL HISTORY		
Sterility		past: - G1 → FTD/
Dyspareunia		Q2 / 5 yrs
		G2 → FTD/ P/07/
		3 yrs
		G3 → 5A at
		4 MA
5. OBSTETRIC HISTORY		
F. T. N. O.		Total No. of confinements G4 → PP
Abortions		Abnormal F. T. D.
Puerperal Infection		Premature labour
		Date and Nature L. D.
6. PREVIOUS OPERATION		
7. VAGINAL DISCHARGE		
8. BOWELS		
9. CLINICAL FINDINGS		
P. A.		
P. V. - G2		
U. R.		
F. B.		
P. S.		
P. R.		
10. OTHER SYSTEMS		
11. INVESTIGATIONS		
Vaginal smear	HB	EC
Cervical Smear	Urin	EC
Endometrial biopsy	PG	
Rubin's test	VDRL	
A. Z. Test	XRC	PA
B. S. R.	-	conclusion
		F u Report
12. FOLLOW UP		

HANDOUT 8.8

CHECKLIST TO OBSERVE THE INSTRUCTIONS AND INFORMATION REGARDING TREATMENT AND FOLLOW-UP

Name of the observer : _____

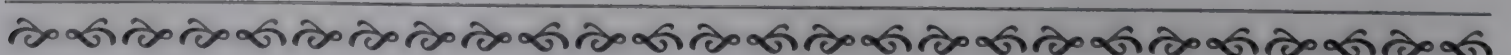
Client number : _____

Date : _____

Time : _____

For each question, please circle the appropriate option

1.	Diagnosis				
1.	Did the provider explain the Diagnosis?	1. Yes	2. No	3. Not applicable	4. Do not know
2.	Treatment				
2.1	Did the provider tell from where to take medicines / drugs	1. Yes	2. No	3. Not applicable	4. Do not know
2.2	Did the provider tell how to take or use the medicine?	1. Yes	2. No	3. Not applicable	4. Do not know
2.3	Did the provider tell for how long to take the medicine?	1. Yes	2. No	3. Not applicable	4. Do not know
3.	Follow-up				
3.1	Did the provider tell her when to come back?	1. Yes	2. No	3. Not applicable	4. Do not know
4	Giving Instructions				
4.1	Did he/she repeat the instructions if patients did not understand?	1. Yes	2. No	3. Not applicable	4. Do not know
4.2	Did the provider ask the patient if she has any doubts/questions?	1. Yes	2. No	3. Not applicable	4. Do not know
4.3	Did the patient ask any questions?	1. Yes	2. No	3. Not applicable	4. Do not know
4.4	Did she ask anything related to sexual relationship or any other sensitive questions?	1. Yes	2. No	3. Not applicable	4. Do not know
4.5	Did the doctor clarify or answer them?	1. Yes	2. No	3. Not applicable	4. Do not know



HANDOUT 8.9

EPISODES FOR ANALYSIS OF REPRODUCTIVE RIGHTS

Case 1

A woman who had two children came to remove the copper-T after three and a half years. She told the doctor that her husband wanted to have another child and she was having profuse white discharge. Doctor asked her for proof that the woman was using the copper-T for three years and also insisted that she could not remove this copper-T unless the woman was willing to insert another one. The doctor also told her that two children are enough. When the patient tried to express her point of view, she was told to go away to the place where she had got the copper-T inserted and was accused of lying about the symptoms. The patient left the room looking dejected.

Case 2

A woman came for a pregnancy test. While checking, the doctor asked her if she wanted to have the child. The patient replied in the affirmative. The doctor looked at her paper and said in a raised voice, "You already have two children, don't you? So why do you want to have another one? Two children are more than enough, don't you understand?" The woman said, "my husband wants it, what can I do?"

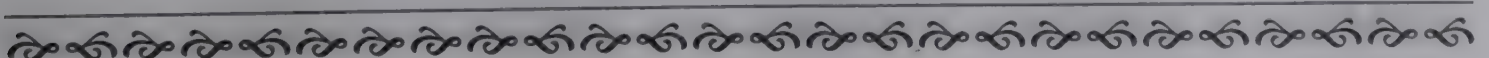
Case 3

After examining a patient internally, the doctor asked the patient, "Are you accompanied by your husband?" When the woman said, 'yes', the doctor asked her to call him in. The doctor told the husband, before explaining to the woman, "She has got 'gaanth' (a lump or a swelling) on her 'pishvi' (Uterus). Get all her investigations (tests required before the surgery) done. You need to donate blood for the operation or get a donor's card to get the blood from the blood bank. One never knows she may need a bottle or two. After she is taken for the operation nothing can be done so keep the blood ready. The operation is big because the 'gaanth' is big. Therefore it is essential to remove her 'pishvi' and anyway, now, what does she need the 'pishvi' for? She does not want to have children; she does not get her periods..."

While the doctor talked to the woman's husband over her head, she looked increasingly uncomfortable and worried. When the patient heard the doctor's last words, she immediately tried to say, "No, no, I still get my period." The doctor dismissed this by saying, "Oh, but it does not make any difference. Now you come after your menses for the operation."

Case 4

The doctor told a woman who had come for antenatal care (ANC) not to have intercourse with her husband. The observer asked the doctor whether she could tell this to the patient's husband and asked the woman whether her husband was accompanying her. The husband was waiting outside the OPD and the patient was ready to go and call him but the doctor said that she did not have time to talk to the husband.



Case 5

A woman wanted a Copper-T instead of tubal ligation (TL) after the MTP. She has already had two children aged 5 and 3 years. The doctors insisted that she choose TL as her younger baby was three years old. She revealed to the observer that she was reluctant to accept TL as a method because she was concerned about the aftercare. She lived in a loft, which had a steep ladder, and she had to fill water everyday from a tap in the neighbourhood and was worried about climbing the ladder carrying the weight. She wanted the Copper-T till she could arrange for some relative to come and stay with her who could help her to fill the water. Also she wanted the operation after two months when her children's exams would be over.

Case 6

A woman came to the OPD requesting for MTP. She already had two daughters. The doctors refused to do only MTP and insisted on also doing a tubal ligation. The woman was also anaemic. She kept repeating her request for an MTP while agreeing to getting a copper T inserted. She left the OPD, crying. Outside the OPD, she and her husband started discussing what had happened inside the consultation room. From this conversation the observer found that the couple had already done the Amniocentesis (foetal sex determination test) and wanted to abort the female foetus, as they wanted a male child. During the conversation the woman kept telling her husband, "Let's keep this baby and do the TL or let's go for TL after the abortion". The husband got angry and started shouting at her. Finally they left the hospital saying that they would go to a private clinic.

Case 7

The mother of one child came for an abortion. She started crying, when the doctor asked her the history of her previous deliveries. She kept insisting that she wanted to abort this baby. The doctor patiently asked her for reasons. After sometime the woman revealed that her first child was mentally retarded and she had had two still births after that. She said that she was scared that this time too she would have an abnormal child. After listening to her carefully, the doctor assured her that she, the doctor, would take all the care and precautions to see that the child was healthy. The doctor referred the patient and her husband for a blood test and advised her to come regularly for the follow up. The patient looked relieved and satisfied.

Case 8

A new patient came to the OPD and the doctor started interviewing her for the history.

Dr. : Kitna bachha hua? (How many children do you have?)

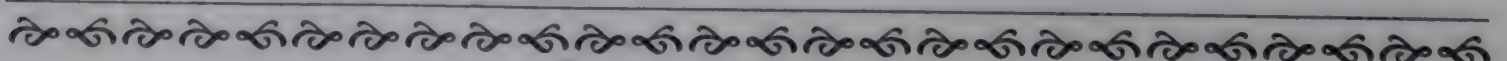
Patient : Do (Two)

Dr. : kya tu abhi phir se pet se hai? (Are you pregnant again?)

Patient: Nahi (No)

Dr. : Yeh mahine mein masik aaya tha? (Did you get your menses this month?)

Patient : Han (Yes)



Dr. : *Phir bachha chhahiye kya? (Do you want another child?)*
Patient : *Nahi (No)*
Dr. : *Phir aapko kya chahiye? do bachhe hai na gharpe? (You have two children at home then what more do you want?)*

The patient removed a small piece of paper and gave it to the doctor. The doctor spoke out impatiently, "yeh sab hamko mat batao (Don't show me all these notes)", and threw the paper on the floor. The patient got very scared and went out of the OPD. The observer picked up the paper which the doctor had thrown. On the paper was written (in broken Hindi) 'Do bachha hoke mar gaya. Phir char mahina masik nahi aaya. Phir kabhi masik aata hain, kabhi nahi aata hai. Thodasa khoon jata hai. Phir pet mein bhi dard hai. Abhi bachha chahiye (Two children died. Then she did not get her menses for 4 months. Now in some months she gets her periods and in other she does not. The menstrual flow is very little. She also has pain in the abdomen. Now, she wants to have a child).

On reading the paper, the observer went out of the OPD to look for the woman. She was standing outside with a scared look on her face. The observer asked her whether that paper belonged to her. She said, "ha, hame bolneko ata nahi, is liye aadmi ne likhke diya hai." ("Yes, my husband has written this because I cannot speak Hindi and cannot express my problem.")

The patient was asked to come in again and a student doctor took her history. The doctor had to struggle to understand the patient because of her difficulty to talk in Hindi, but the information on the slip helped the student doctor to identify her real problem and get started on the history taking.

HANDOUT 8.10

REPRODUCTIVE RIGHTS

REPRODUCTION AND SEXUALITY AS HUMAN RIGHTS

Reproductive and sexual rights are founded on many principles common to human rights that governments are obligated to respect, such as

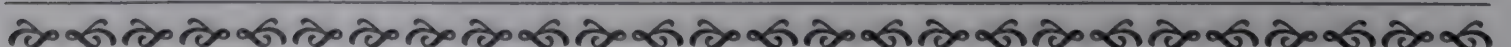
- Human dignity
- Equality and non-discrimination
- Bodily integrity
- Self-determination (the ability to make decisions for one's self)
- Privacy
- Liberty and security of person
- The right of access to health care, including reproductive health care
- The rights of the child

Another way of thinking about reproductive and sexual rights focuses on the ultimate goal of equality. Since control over reproductive and sexual life is central to women's existence, women need to have these rights in order to be able to participate fully in society, not just in a manner equal to, or identical with, men but in a fair manner that addresses women's needs. Equality for women in their reproductive and sexual lives improves the conditions of men and children as well; when these human rights are more respected in society, the standard of living is higher, birth rates lower and health care better.

Reproductive Decision-Making

Women and girls make many decisions about their reproduction and sexuality, including:

- Whether to obtain information regarding sex
- Whether to engage in sexual activity and with whom
- Which contraceptive methods to use, if any
- Whether to request a male sexual partner, including a spouse, to use a condom
- Whether to have children
- Whether to seek medical attention during pregnancy
- With whom to have children
- When to have children
- How many children to have
- Spacing of children
- With whom to bring up children
- Whether to abort an unwanted pregnancy



However, women's choices are often imposed or limited by direct or indirect social, economic and cultural factors. For example, in some countries where women are allowed little participation, or where governments impose strict population policies, women may feel forced to decide between abortion of the female foetus, infanticide of the female newborn baby or neglecting a female child until she dies. In many countries an unmarried pregnant girl is told to have the baby quietly and then give the child away to a married couple. Otherwise, her only other option is to raise the child alone in poverty with few prospects for the future.

THE LEGAL FOUNDATIONS OF REPRODUCTIVE HUMAN RIGHTS

- The right to liberty and security of the person: Universal Declaration of Human Rights (UDHR), Article 3; International Covenant on Civil and Political Rights (ICCPR), Article 9 (1).
- The right to health: International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12.
- The right to non-discrimination in the provision of health care and in the family. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Articles 12(1), 16(1).
- The right to marry and to found a family: UDHR, article 16(1); CEDAW, Article 16(1); ICCPR, Article 23(2).
- The right to freedom from arbitrary or unlawful interference with privacy, family and home: ICCPR, Article 17(1).
- The right to enjoy scientific progress and consent to experimentation: ICESCR, Article 15(1).
- The right of sexual non-discrimination: CEDAW, Article 1-2; UDHR, Article 2; ICCPR, Article 2(1); ICESCR, Article 2(2).
- The right of men and women to have, on a basis of equality, access to family planning: CEDAW, Article 12(1).
- The right of rural women to family planning: CEDAW, Article 14 (2) (b).

HANDOUT 8.11

ROLE-PLAY SITUATIONS ON CONTRACEPTION COUNSELING

Case study 1

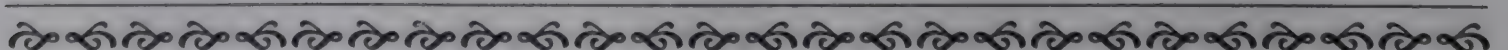
A woman has three children, two sons aged 7 yrs. and 5 yrs, and one daughter 3 years old. The woman is a housewife while the husband works as a salesman in a cloth shop. She comes with her husband to you because they do not wish to have any more children. How will you deal with the situation?

Case study 2

A woman has a two year old daughter and has been using oral pills since the last year. She comes to you saying that nowadays she gets headache and nausea which she is associating with intake of the pills. She wishes to discontinue the pills but does not wish to have another child for next two years. Also she is scared of Cu-T as she has heard from her neighbour that there is heavy bleeding during menstruation. She has come to you for consultation.

Case Study 3

A woman comes to you saying that she is getting a lot of foul smelling white discharge and pain in lower abdomen since three months now. She had got an IUD inserted a year back and she associates the discharge with the IUD use and wants to discontinue it. She has two daughters aged 7 and 5. Advise her. (On examination it was found that she had a reproductive tract infection)



TECHNICAL INFORMATION ON CONTRACEPTIVE METHODS

IUCD - Copper-T

When can a Cu-T be inserted?

1. After MTP
2. Last day of menstruation
3. After a delivery

Most useful for maintaining spacing between children

Complications

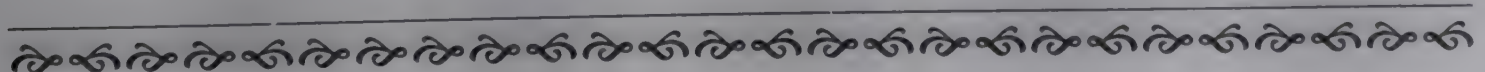
1. Problems during menstruation
 - Abdominal pain
 - More bleeding than normal
 - Irregular period
2. White discharge
3. Displacement or expulsion of cu-T
4. Ectopic Pregnancy
5. Conception along with Cu-T

Types of IUCD

1. Cu T 200 B (Government Supply)
2. Multiload 250/375
3. Silverlily
4. Merina (IUD with hormones)

Follow-Up

1. One month after insertion, or after the first period after insertion
 2. After every 6 months
 3. Whenever woman feels discomfort or experiences problems
- Cu-T is effective immediately after the insertion
 - When used for spacing between two children, a woman should plan for the next conception immediately after the removal of the Cu-T.
 - Once family is complete and the couple does not want any more children they should opt for terminal methods like Tubal Ligation (T.L.) or Vasectomy because it could be harmful to keep changing Cu-T.
 - Cu-T never causes cancer. But if proper follow-up checking is not done, frequent infections could lead to cancer.



Oral Contraceptive Pills

Advantages of pills

1. Helps in regulating menstrual period
2. Prevents excessive bleeding during menstruation
3. Increase in weight

Types of Oral Contraceptive pills

- Hormonal
- Non-hormonal
- Hormonal pills
 - Sequential pills
 - Combined Pills
 - Mini Pills

It is absolutely necessary to take a pill everyday without fail

Harmful side effects of pills

1. Excessive weight gain
2. Less bleeding during menstruation
3. Post pill Amenorrhoea
4. Increase in blood pressure

These effects are observed only after continuous use for many years

Condom

Not very popular

Failure rate is due more to irregular and faulty use

Other advantages

1. Prevention from STIs
2. Prevention from AIDs

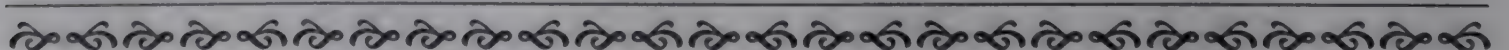
Some people (men and women) experience allergy due to Condom

Tubal Ligation

Woman's sterilisation method

Types

- Laproscopic T.L.
- Abdominal T.L.



- Laparoscopy
 - One day surgery
 - Can be done by use of general or local anaesthesia
 - Only one stitch
 - Not much after care required
- Abdominal
 - Done by opening abdomen

Most suitable or advantageous

1. For women who are medically fit
2. When done along with the MTP
3. After a delivery
4. On the last day of menstruation

Pre-operation –Investigations

1. Hb/ CBC/ ESR
2. Blood group
3. Urine
4. X-ray chest - PA

Vasectomy

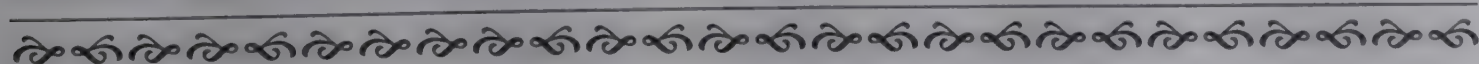
- Not very popular
- Need to promote this method

Advantages of Vasectomy over T.L.

1. No need for anaesthesia
2. No need for admission in the hospital
3. Very easy to perform (no scalpel vasectomy)
4. No need for post-operation rest

Role of men in contraception decision- making

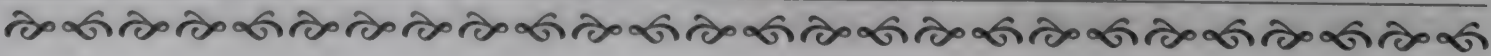
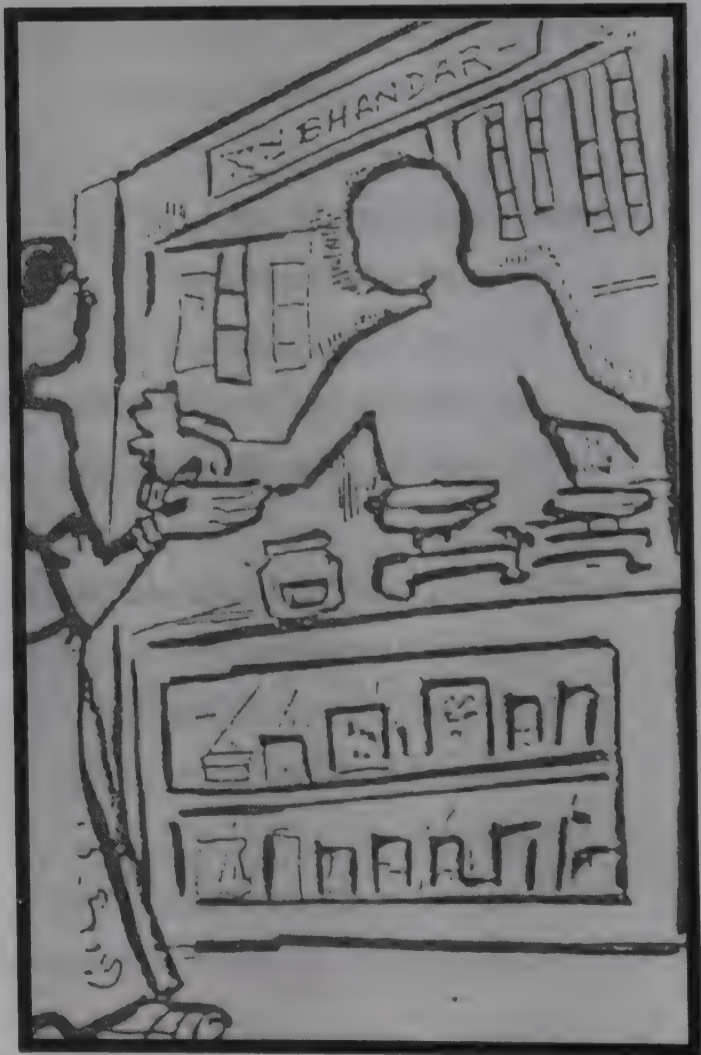
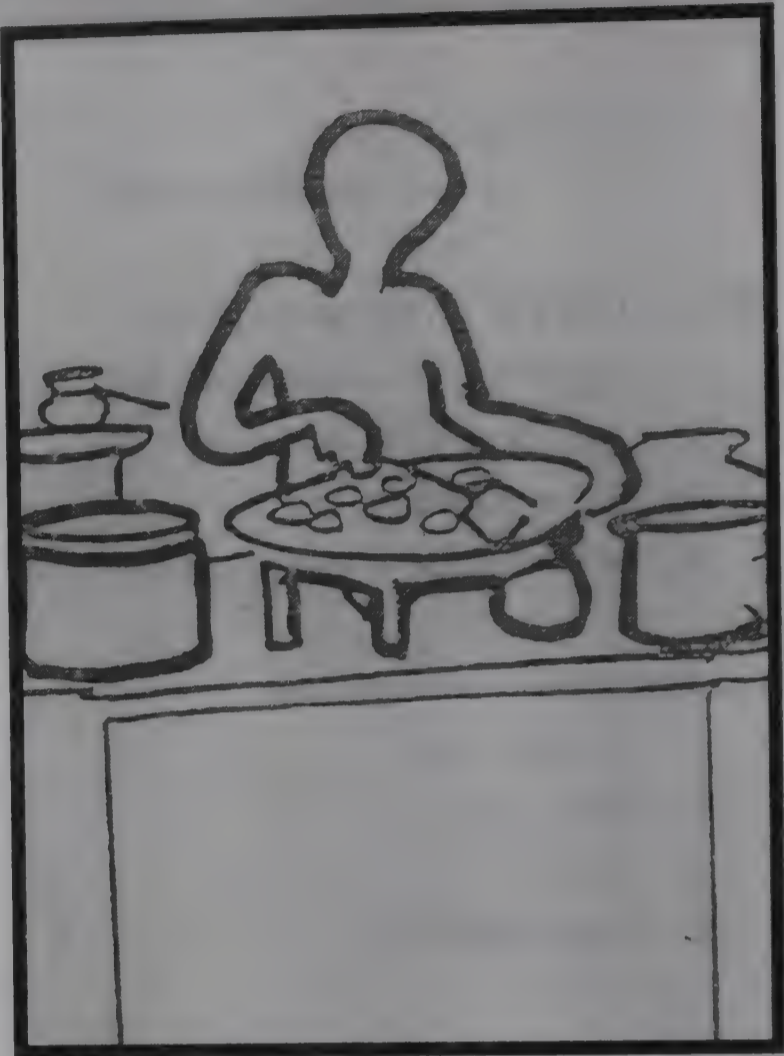
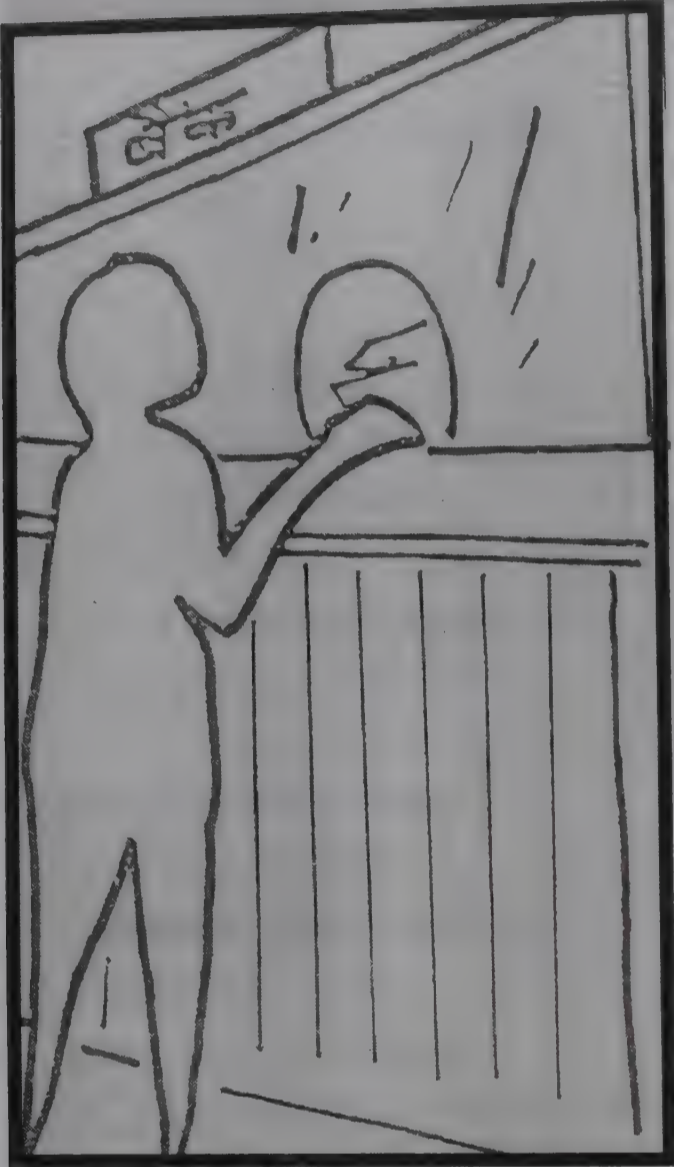
1. Initiate dialogue and communication with the partner and decide together
2. If woman experiences some discomfort with adopted method accompany her to the doctor
3. Be aware that contraception methods for men are safer and make a responsible decision to use them
4. If woman is not medically fit for T.L. volunteer for vasectomy
5. Respect woman's wish and support her at home and outside

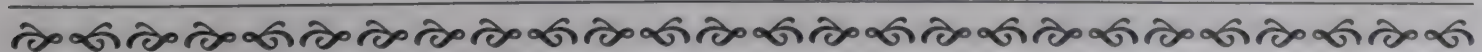
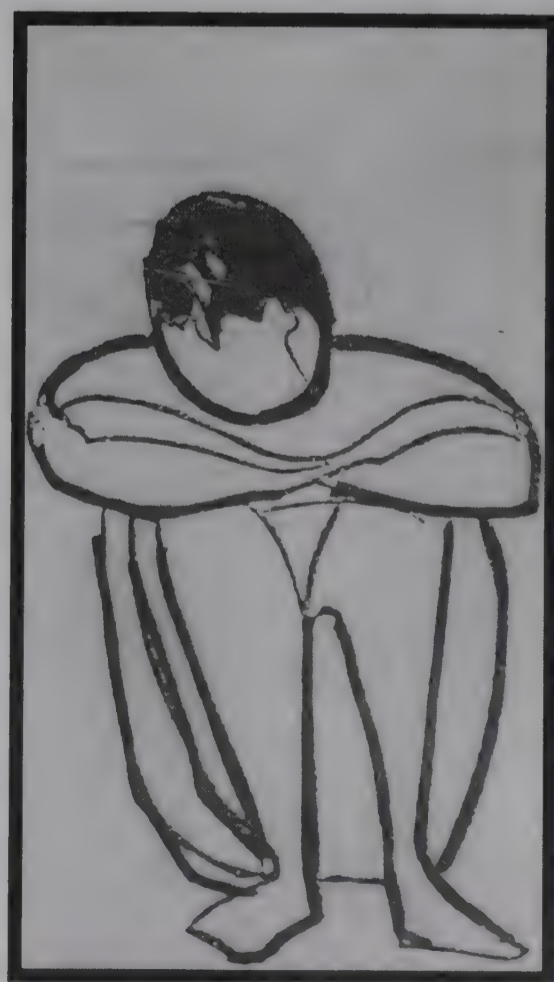
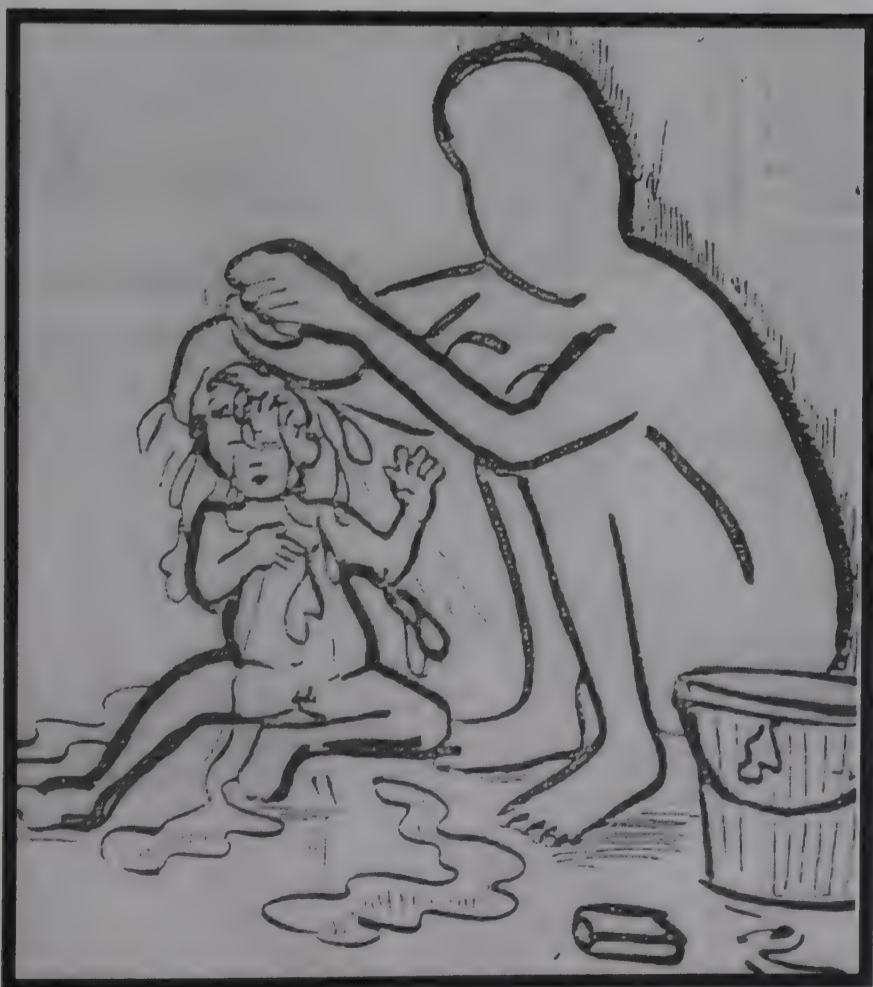


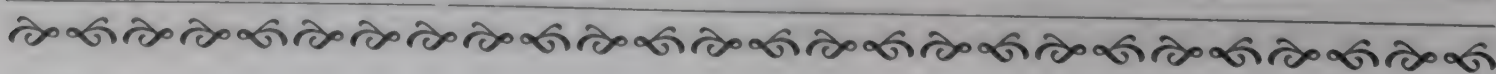
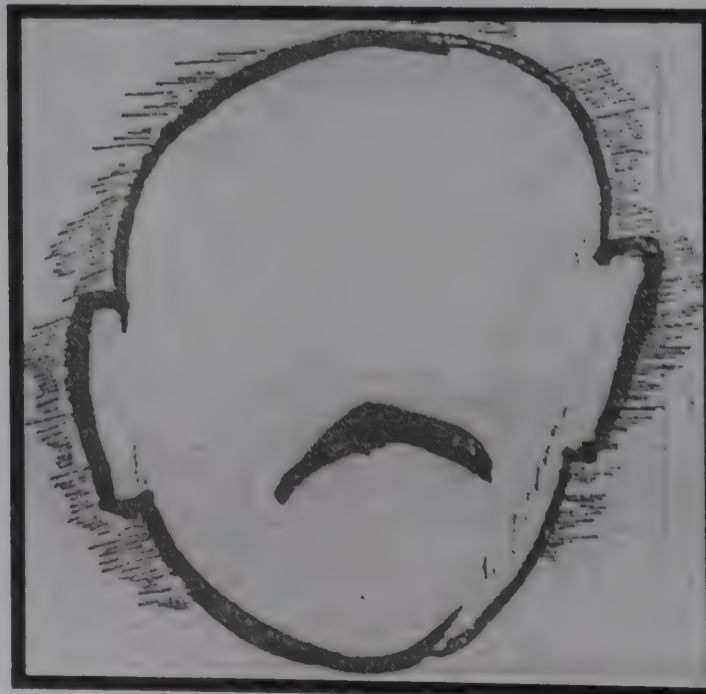
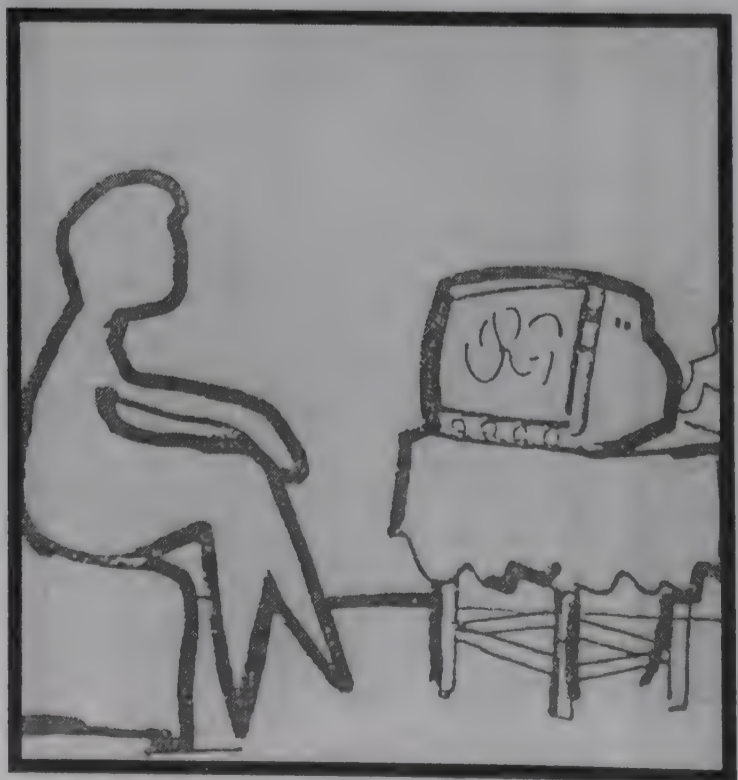
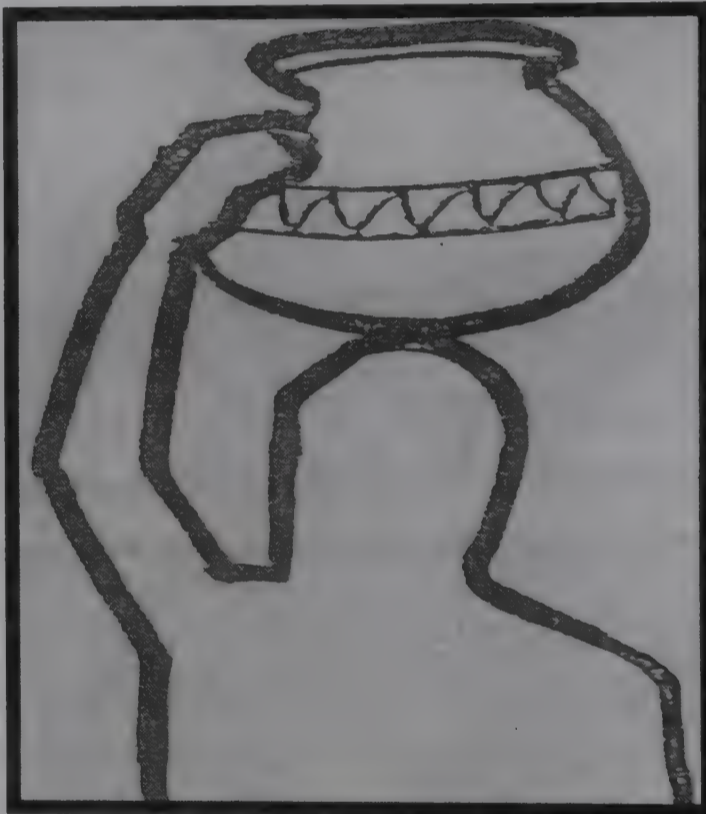
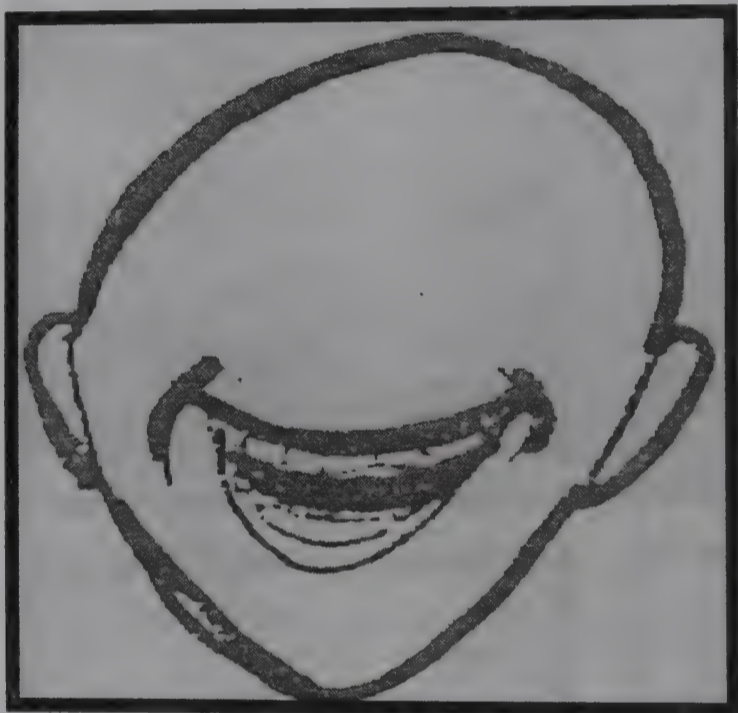
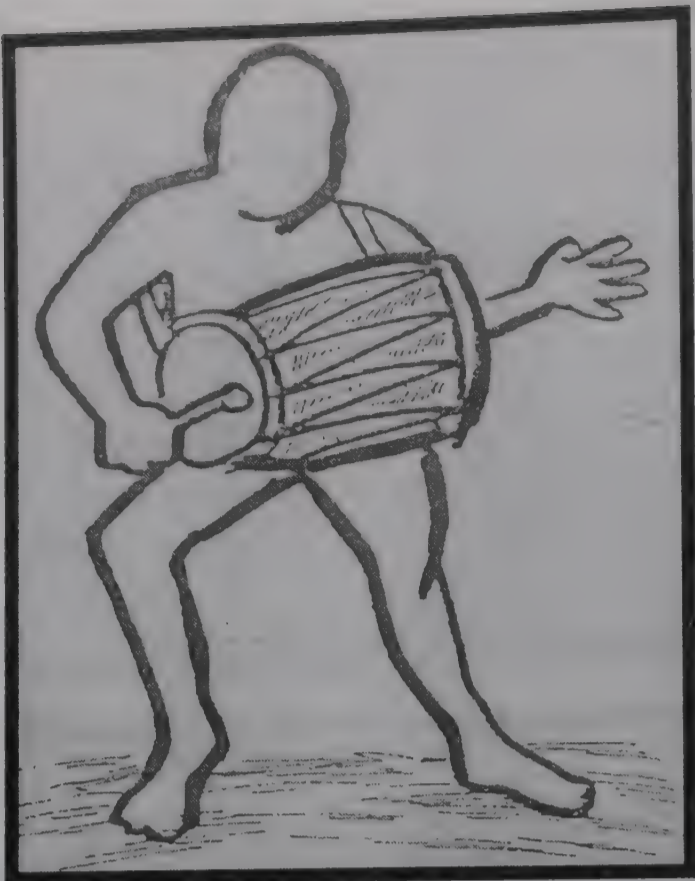
OVER-HEAD TRANSPERENCIES

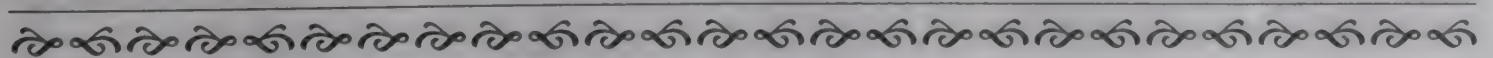
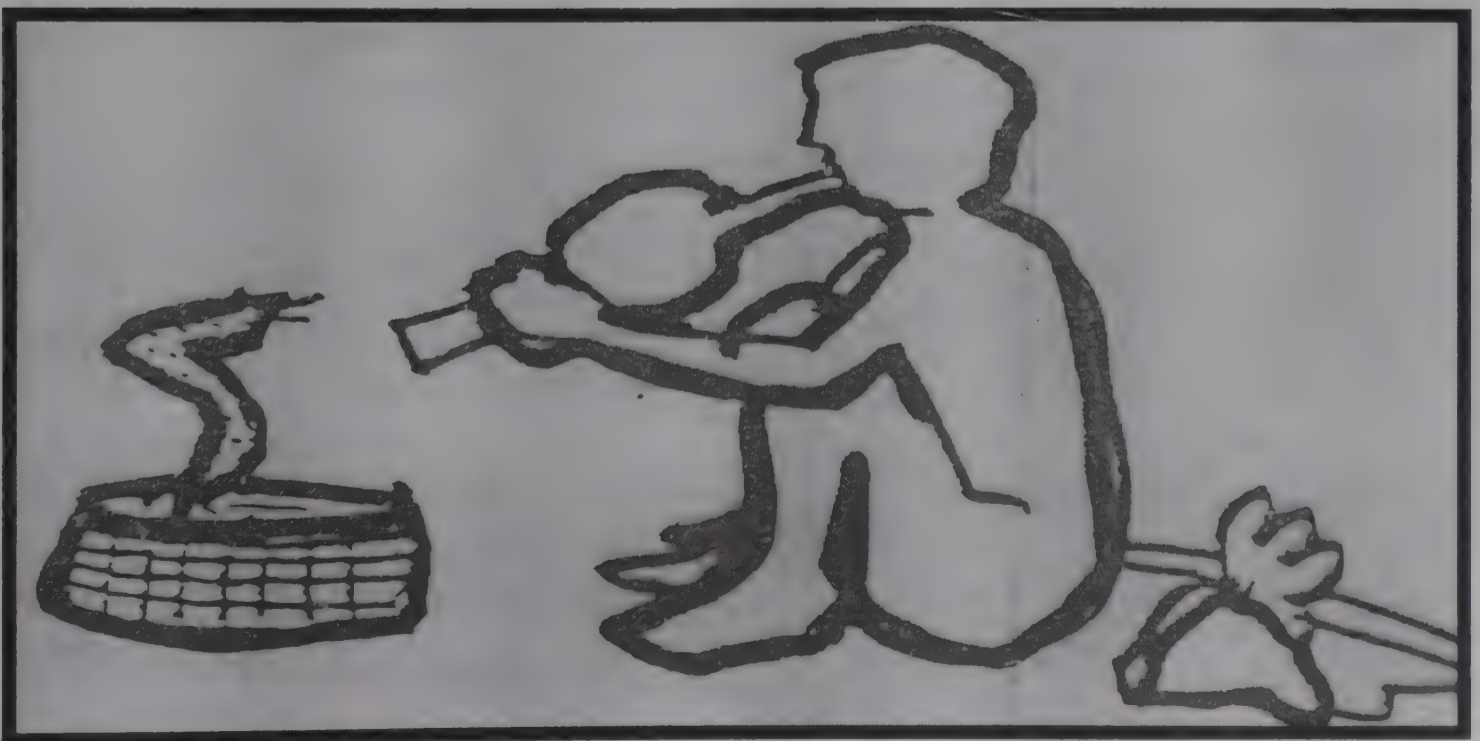
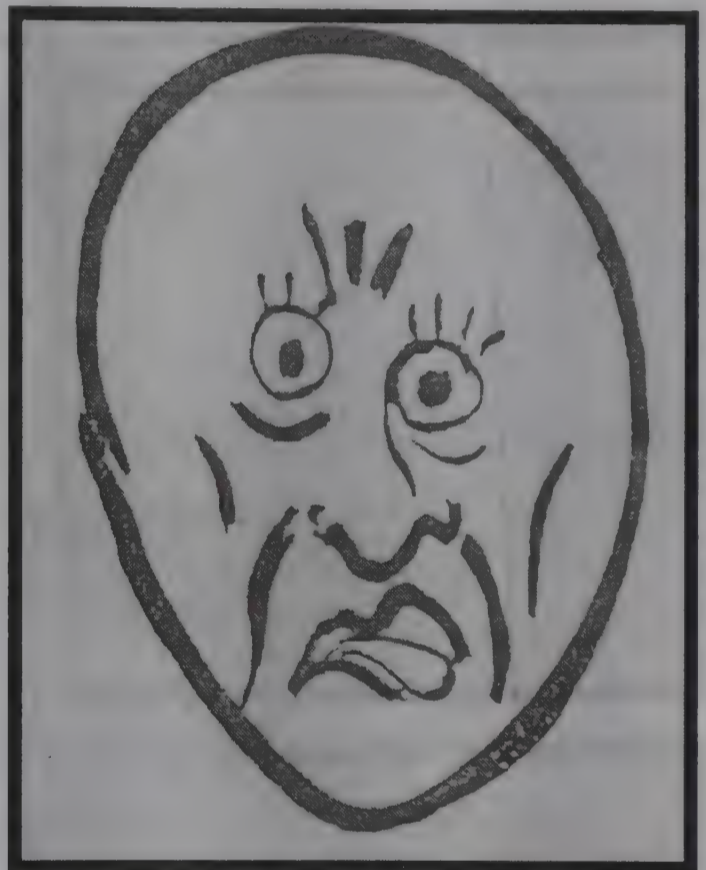
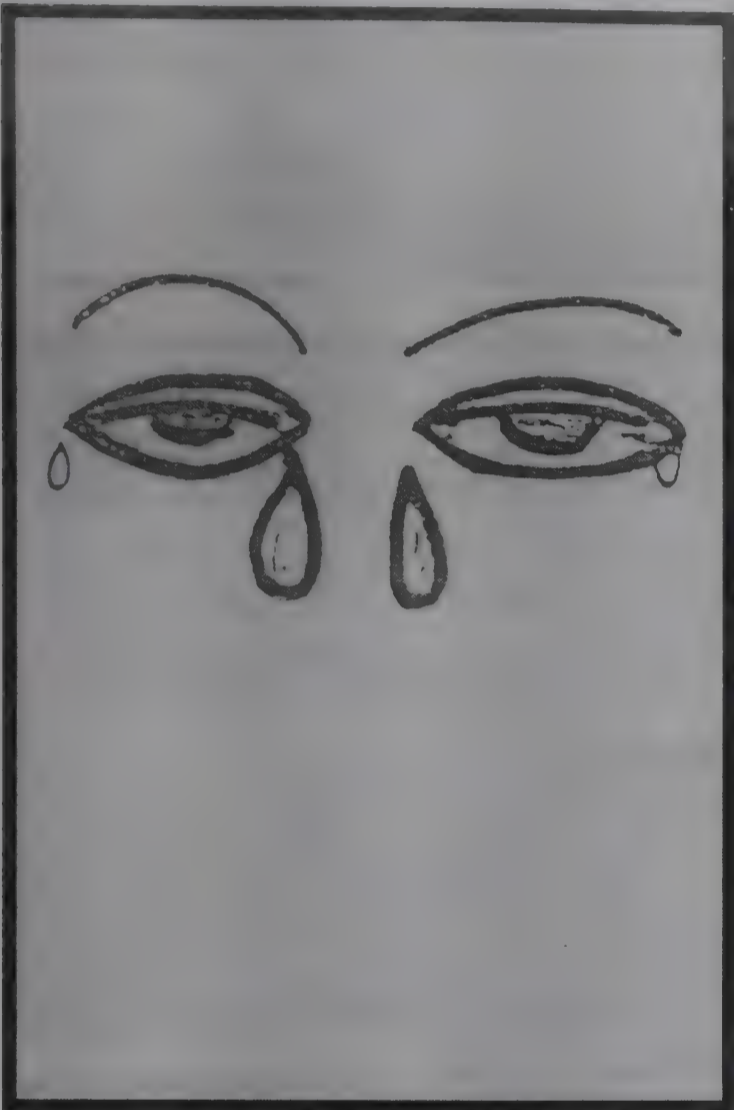
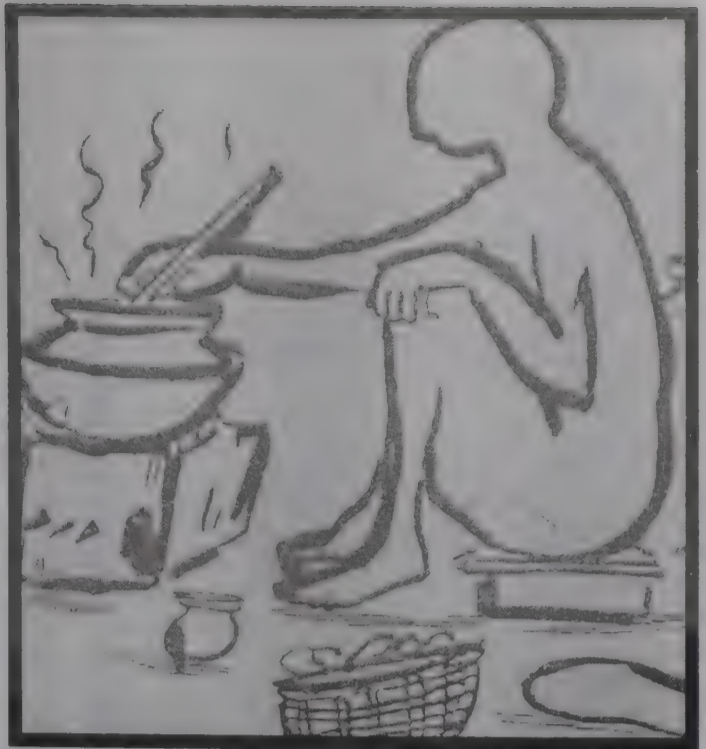
OHT 8.1

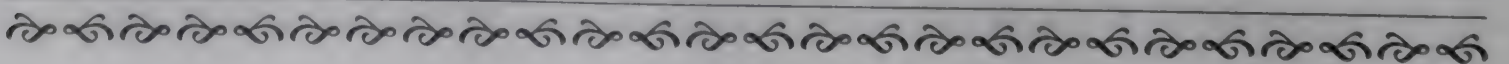
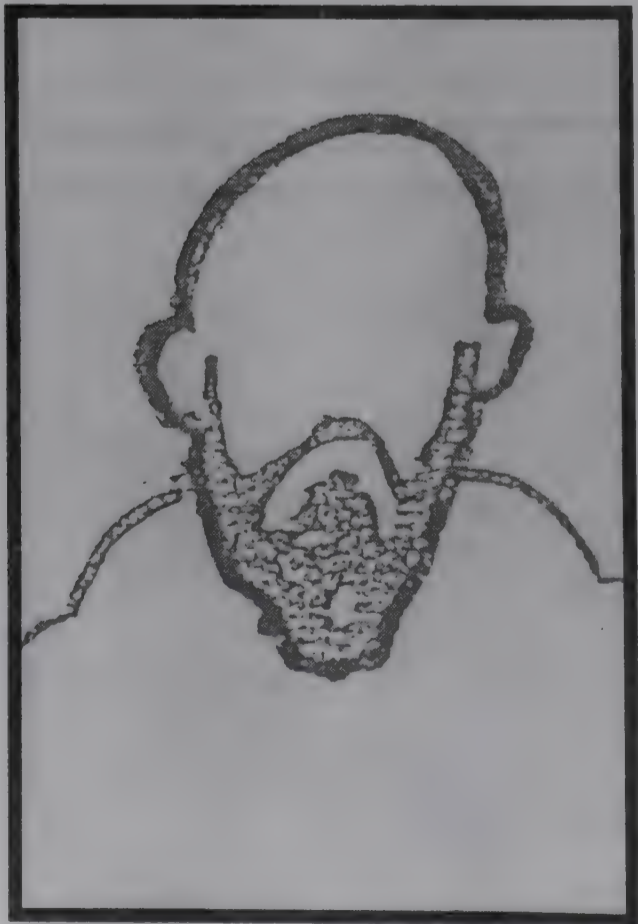
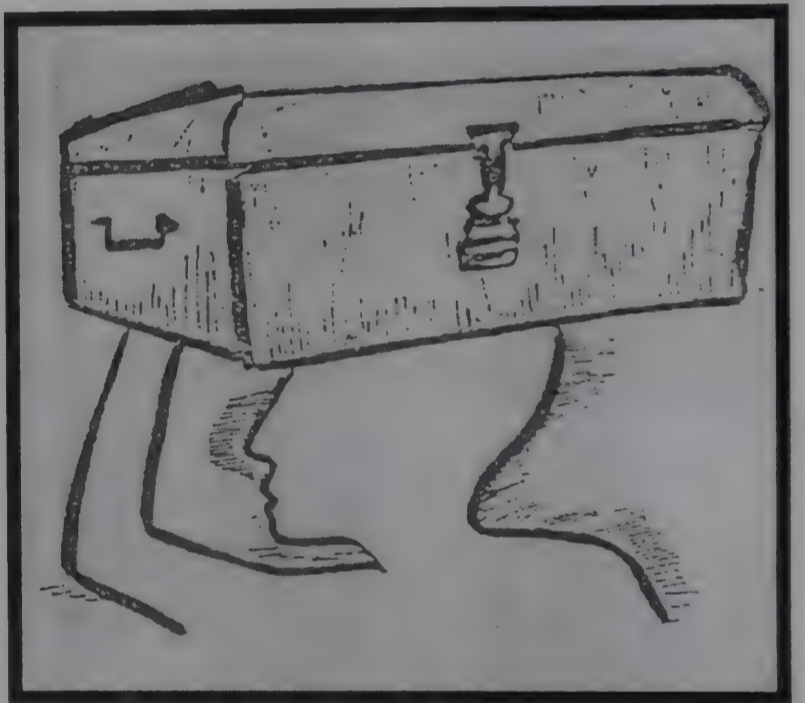
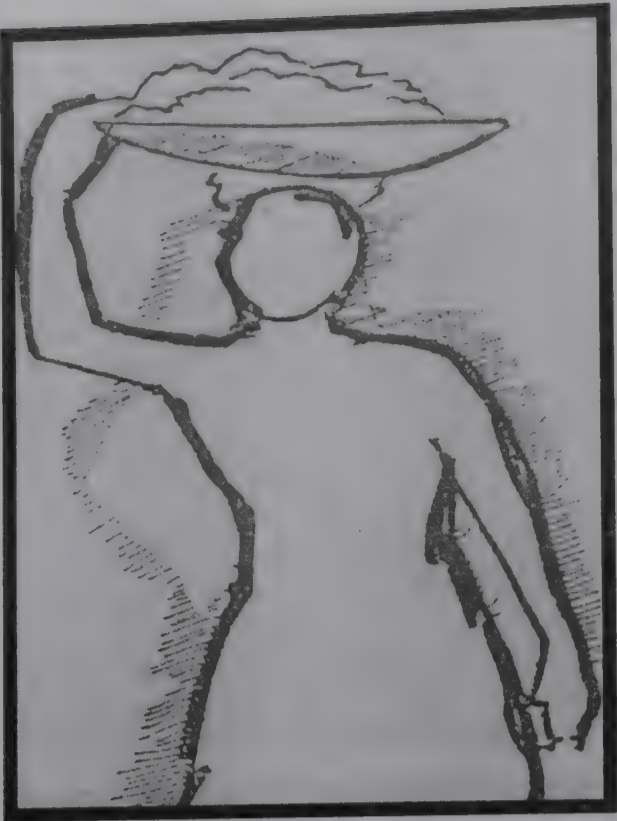
GENDER STEREOTYPE PICTURES

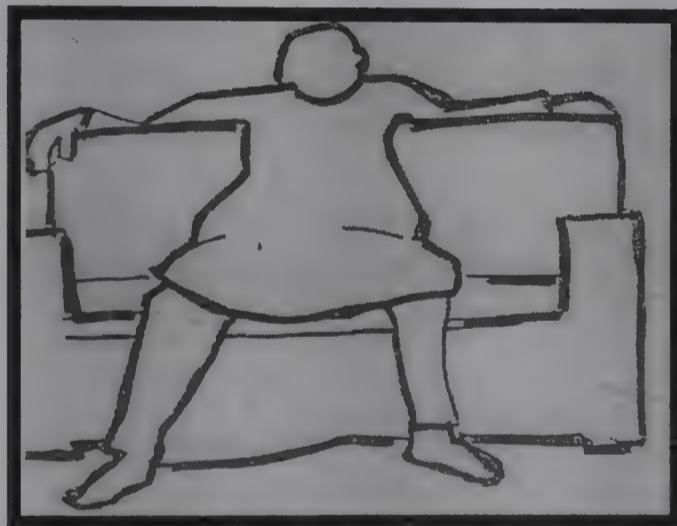












OHT 8.2

WHAT IS GENDER?

Definitions of Sex and Gender

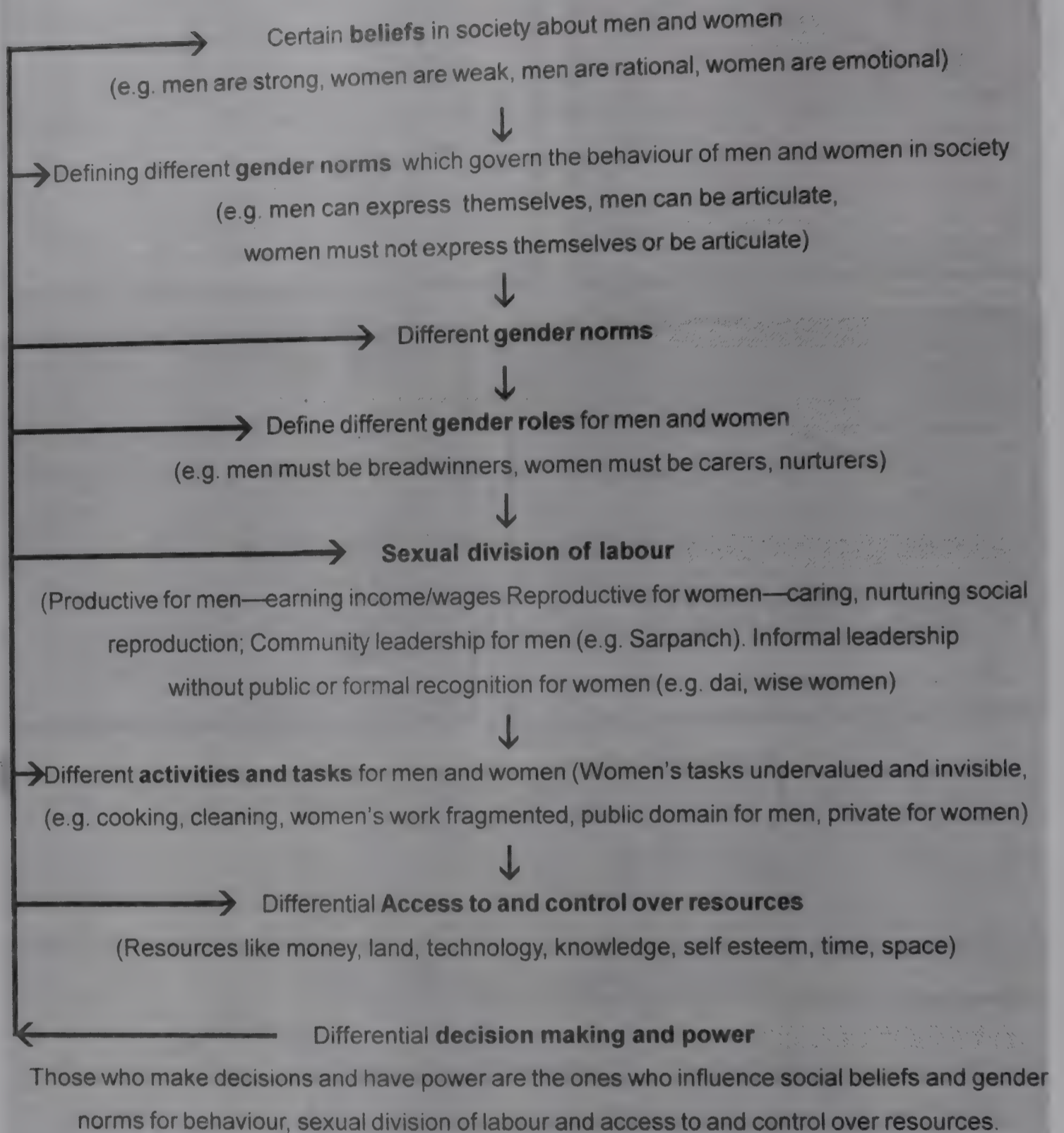
- Sex refers to the biological differences between men and women.
- Gender refers to roles (behavioural norms) that men and women play and the relations that arise out of these roles. They are socially constructed, not physically determined.

Characteristics of Gender

- | | |
|-----------------|---|
| • Relational | • Socially Constructed |
| • Hierarchical | • Power relations |
| • Changes | • Changes over time |
| • Context | • Varies with ethnicity, class, culture, etc. |
| • Institutional | • Systemic |

OHT 8.3 (A)

GENDER AS A SYSTEM

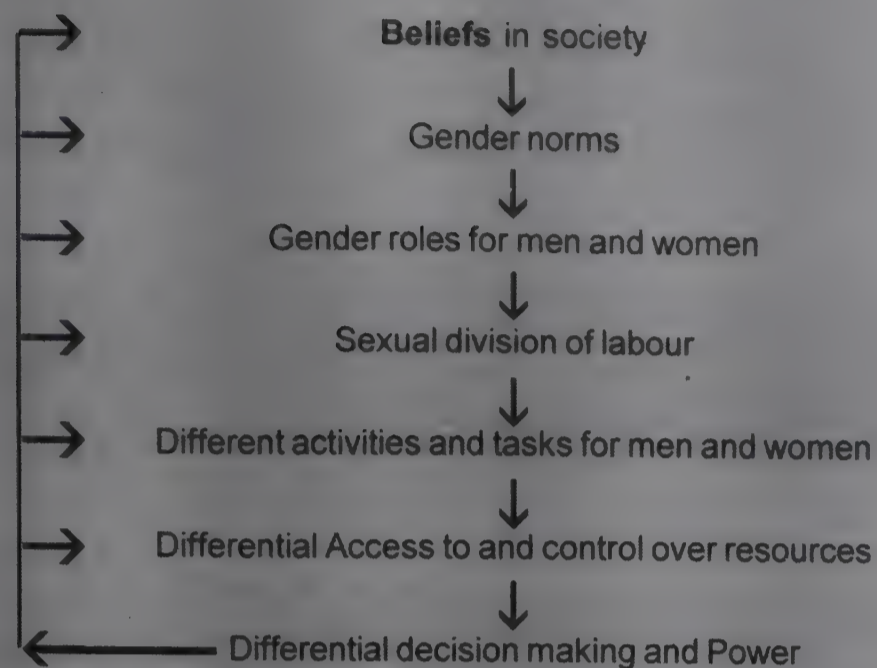


Thus, this is a system which feeds on its subsystems and perpetuates itself. The beauty of the system is that it can be broken anywhere - either by changing social beliefs, or by changing norms for behaviour of men and women, or by changing the work that men and women are supposed to do, or in the allocation of resources. Thus it can be seen that gender constructs can be changed over time, over space, over contexts.

OHT 8.3 (B)

GENDER AS A SYSTEM

How gender works as a system



OHT 8.4

GENDER DIMENSION AND RIGHTS VIOLATIONS

ANAEMIA IN PREGNANCY

Aspect	Gender and Rights Dimension
Causes	Dietary customs; workload; repeated pregnancies/abortions
Response of the family	Accused of malingering; no sharing of workload; no treatment
Response of the individual	Self-blame; works hard despite weakness
Response of the provider?	Not available; blames her for not seeking help in time

OHT 8.5

TYPES OF QUESTIONS

Closed questions

Closed questions are short: answer are in terms of : yes/no/number.

- Are you educated?
- Do you have problems when having intercourse?
- If I understand you well then you are saying that your periods were regular till last year, and then you got MTP (thaili saaf) done, after which you are having heavy bleeding ?

Open questions

Open questions invite respondents to give their ideas, feeling and opinions in their own words. Start with how, what, when.

- Tell me more about your relationship with your husband.
- What do you think about a person having AIDS?

Leading questions

Leading questions are questions which suggest a certain answer

- Do you think bleeding occurred because you traveled so far in the bus?

Judgments

Avoid statements that indicate what you find good or not-so-good.

- What? You have four children already! Do you think it is right?
- It is very good that your husband does not mind using condoms.

Probing questions

Probing questions invite the respondent to talk in more detail about an issue.

- You say you did not come for the follow-up because you had family tensions. What was the family problem you had?

To get the maximum accurate information and facts, in the history-taking one should try to avoid asking leading, judgmental and only closed questions.

OHT 8.6

HISTORY-TAKING IN GYNAECOLOGY

- Be aware of, and sensitive to, the needs of women.
- Provide privacy- visual and audio
- Establish rapport -- make the patient feel comfortable
 - Make her sit down
 - Be respectful
 - Maintain eye contact
 - Ask simple questions in the beginning
 - Be patient
- Ask open-ended questions
- Avoid leading and judgmental questions
- Use local terminology, knowledge of local cultural festivals to determine time of onset of the problem
- Believe in the woman
- Use a gentle tone and avoid judgments to get correct obstetric history
- Sexual history – Are you comfortable talking about sexuality?

OHT 8.7

LIST OF CONDITIONS AND THE INVESTIGATIONS REQUIRED

Menstrual problems

- Haemoglobin (Hb)
- Complete Blood Count (CBC)
- Sonography
- Hormonal assays

ANC

- Blood
- Hb
- VDRL
- Blood group
- Urine
- Proteins
- Sugar
- Sonography

Infertility

For Men	For Women
<ul style="list-style-type: none">• Hb• Blood Group• VDRL• Post prandial blood sugar• Urine• Semen analysis	<ul style="list-style-type: none">• Hb/CBC• Blood Group• VDRL• Fasting and post lunch blood sugar• Urine (routine and microscopic) fasting and post glucose• TSH• HSG• Ovulation Tests• X-ray PA View• USG Pelvis

Hysterectomy

- Hb
- CBC
- Blood group
- Urine (routine and microscopic)
- Blood sugar

OHT 8.8

INSTRUCTIONS ON TREATMENT AND FOLLOW-UP

Possible reasons for non-compliance or failure to come for follow-up

- No money to buy medicines or travel to health care facility frequently.
- May be going out of town
- May not have anybody to take care of her.
- Children small- problems arranging for child care.
- Fallen sick or someone at home was sick
- Arrival of unexpected guests at her place.
- Urgent family matter to attend like death, marriage or festival celebration.
- Violence by husband / family member.
- She forgot the date.
- She could not get leave from work.
- Time was not convenient.
- Reaction to the prescribed medicines
- Heard something about the treatment or operative procedure from neighbours and discontinued the treatment

If a woman fails to follow-up

Avoid saying

- *If you care for yourself, you won't be doing this or would be doing this.*
- *I know or you know better? —who is the doctor?*
- *If you do all that I tell you, you will be all right.*

Instead, one can say

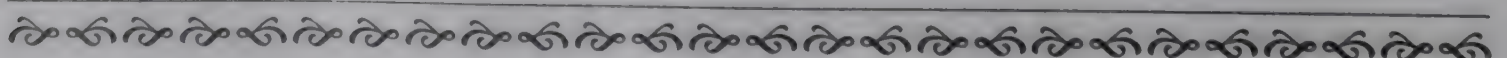
- *It will require both of us to make efforts for your well being, I expect your cooperation, only then I can do my job properly.*
- *Do you think you can do this? Is it possible for you to follow the advice?*
- *Kindly tell me or feel free to express or ask about all your difficulties regarding the prescribed treatment.*
- *Can you tell me next time what your husband or mother-in-law says about this?*

Reassure her

"I have understood your problem and we will try to do all the needful to minimise your problem."

Emphasise woman's responsibility and participation in the treatment process

- Taking the whole course of medicines
- Coming in time for follow up
- Sharing personal problems relevant to her health issues.
- Following advice and preventive behaviour and by expressing openly her inability to do the above.

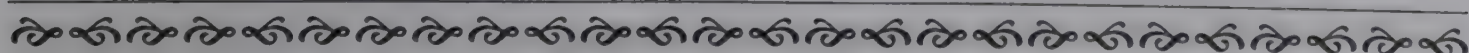


OHT 8. 9

REPRODUCTIVE RIGHTS OF CLIENTS USING CONTRACEPTIVE SERVICES

(Source: IPPF)

- **Right to Access:** Clients can obtain services regardless of sex, creed, colour, marital status or location
- **Right to Information:** Accurate and detailed information related to the benefits and availability of contraception services
- **Right to Choice:** Clients given choice to decide freely whether to use contraception and which method to use
- **Right to Safety:** To be able to practice safe and effective use of contraception
- **Rights to Comfort:** To feel comfortable when receiving services
- **Rights to Privacy:** To have private environment during counselling or services
- **Right to Confidentiality:** To be assured that any personal information will remain confidential
- **Right to Dignity:** To be treated with courtesy, consideration and attentiveness
- **Right to Continuity:** To receive contraceptive services and supplies for as long as needed
- **Right to Opinion:** To express views on services offered



OHT 8.10

WOMAN CENTERED CONTRACEPTION COUNSELLING

Mission Statement

Statement of Purpose for which our programme exists

- To provide gender sensitive, women- centered Reproductive Health Services to our clients.
- With special reference to Contraceptive Counselling in Public Health Sector

Our Goals

- Make the clinics
 - Client- friendly
 - Men- friendly
- Respect client's dignity
- Protect client's privacy
- Assure confidentiality
- Inform them adequately about various contraceptive methods
- Give them Right to Choose
- Prepare concrete Plan of Action for giving Quality Care

Identify Constraints

- Infrastructure
 - Space
 - Restructuring Plans Budget
 - Curtains, Corner
 - Furniture
 - Manpower
- Training Needs
 - Topics, Time, Methods
- Community Education Material Requirement
- Recurring expenses
- Face-Lift to the Clinic
- Attitudinal Change
- Suggestions/Solutions/Modifications in Existing System

Reproductive Health Services

Offered

- Ante Natal Care
- Post Natal Care
- MTP
- Contraception
- RTI/STI/Genital Cancers

Need to Be Added

- Comprehensive Care for RTI/STI
- Adolescent Health Care
- Well Woman Clinic
- Menopause Clinic

Paradigm Shift

Patients

- I know what's good for her
- Prescribing
- Telling
- Advising

Clients

She can choose what she feels is good for her

Informing
Counselling
Helping

Client-Friendly Clinic

- Women should feel like attending
- Recommending it to others
- Dignity
 - Do not undress her without covering her properly
 - Instructing UG Students
 - Restricting number of educational Examinations
 - Addressing her with respect
 - Make her and the accompanying person comfortable

Men-Friendly Clinic

- Current clinics unfriendly to Husbands
- Men remain uninformed/uninvolved resulting in low participation
- Concept of Couple Counselling
- Men are Decision- Makers in the family
- Men participation vital
 - Condom Use & Safer Sex Practices
 - Vasectomy
 - STI/HIV Transmission Prevention

Client's Privacy

- Cabins/Curtains/Partition
- Allowing ONLY one Client with her accompanying person in the cabin at a time
- Not only while examining but even during CONVERSATIONS, Sample Collection
- Constraint – Inadequate Space

Confidentiality

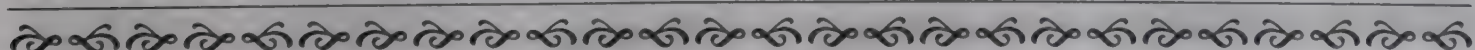
- Privacy
- Talking in soft tone
- Avoid quoting her problems/diseases
- Avoid writing embarrassing facts on the Hospital Record like Unwed Primi

Information about Contraception

- Benefits – Contraception & Non-contraception
- Side effects & adverse effects
- How much?
 - What is Too Much?) Client dependant
 - What is Too Little?)
- Client should understand & grasp
- Standardised IEC Material
 - Simple & easy to understand
 - Focused key messages

Ensuring Understanding

- Exit Interviews
- Direct Observation Technique
- Test of Understanding
- Information
 - Adequacy
 - Accuracy



OHT 8.11

REFERRAL GUIDELINES

Before referring

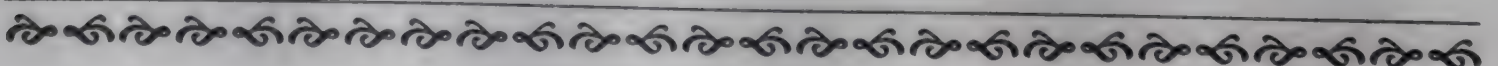
1. Know complete information about the referral centre
2. Make timely referrals.
3. Build rapport with referral centre staff
4. Consider Time, Distance, Cost when deciding where to refer
5. Discuss financial constraints, if any, with the patient
6. Explain reason for referring, importance of attending the referral unit and implications
7. Be aware of reasons, difficulties that the patients may have for not visiting the referral centre.

Reasons or barriers for not attending the referral services

- Past negative experience with a particular referral unit
- Not convenient in terms of cost, distance, time
- Urgent work
- Patient was unwell
- Restrictions from family members

How to deal with the problems of failure to attend referral centre

- Ask reasons for not visiting and suggesting alternative referral centre if necessary.
- Check whether patient wants to go to a particular centre of her own choice for referral and reasons for that
- Fill the referral slip completely.
- Follow-up referral by asking for feedback from patients and doctors from the referral unit



ANNEXURE 8.1

SAMPLE OF POSTER ON THE INVESTIGATIONS TO BE DISPLAYED IN THE OPD

Investigations	Cost	Why is it done	Where is it done	What time
Hb		OPD No.		
CBC				
Sonography (USG)				
Urine				
Stool				
X-ray				
Blood sugar				
Blood group				
ECG				
VDRL				
Semen analysis				
Serum TSH				
Proteins				
Hormonal assays				
LFT				
RFT				
Serum Prolactin				

Note: One can add the details depending on the facilities available in the hospital

COMMUNICATION AND COUNSELLING AROUND ADOLESCENT GIRLS' HEALTH ISSUES

Adolescence is a transient phase, marked with storm and stress. All age groups have their somewhat clear-cut developmental demarcations, but when we talk about adolescents, the range may have no limits. As we all know it is a stage where the person is neither a child nor an adult, so neither the norms set for children, nor those for adults apply to them fully. In this stage of life adolescents want to move away from adults and establish their own identity. Therefore, they may not appreciate any long term relationship — with parents or guardians, or any adults, and are rebellious towards adults in authority positions. It becomes a challenge for adults to build rapport with adolescents. This very thing makes counselling adolescents a very unique feature.

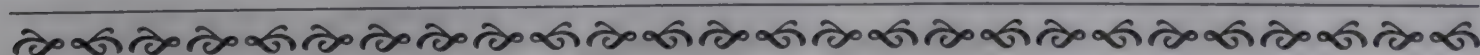
This confusion along with varied physical and emotional changes, changing expectations and now the effect of mass media and internet makes this group very vulnerable to experimentation, rebelliousness and risk-taking behaviour. Hence counselling the adolescent population requires special skills. Though adolescent boys and girls both may require counselling, this module focuses on the needs of adolescent girls, in particular on unmarried, adolescent girls. Handling of adolescents is an extremely skillful job, requiring knowledge of the developmental stages, and emotional maturity. The seeds of healthy, confident and meaningful womanhood could be laid in adolescence.

Adolescent Girls coming to the Gynaecology OPD

Adolescent girls coming to the gynaecology OPD generally come with problems like menstrual disorders, reproductive tract infections with symptoms like white discharge and itching on the genital area and unwanted pregnancy without marriage. Some may also come with indications of sexual violence but they do not report these. Due to the sensitive situations they find themselves in, the counselling techniques used for adolescents differ in their approach.

Many of the girls are lost in the crowd of women waiting in the OPD. The OPD looks like a place not meant for them. They are scared of internal examination. In case of primary amenorrhea, if the doctor wants to check whether their secondary sexual organs have developed or not they also have to undergo breast examination which may be extremely embarrassing for them. Adolescent girls who come with menstrual disorders or with reports of white discharge find it difficult to give consent for internal examination. They find the OPD atmosphere inhibiting and scary. This leads to tension resulting in rude behaviour from the doctors or other staff and sometimes the girls go without the consultation.

In case of unwed pregnancies the girls have to face the awkward questions of the doctors, and other staff who show more than necessary interest in their case. All these situations make adolescent girls



a vulnerable group among patients who come to the Gynaecology OPD. Therefore they need special attention to reduce their fear, shame for seeking help from a doctor and for the examination. They also need counselling to cope with the trauma of unwanted pregnancies and MTP.

Module Objective

The purpose of this module is to develop sensitivity and understanding of the social problems associated with the health problems and needs of adolescents, particularly unmarried adolescent girls, and to develop skills for counselling adolescent girls.

Session 1 What happens in Adolescence?

Learning Objectives

At the end of the session the participants will be able to

- reflect on their personal experiences and relate it with adolescents' needs
- realise the importance of understanding adolescent behaviour

Time 1 hour 30 minutes

Resources Handout 9.1 Understanding Adolescence

Methodology

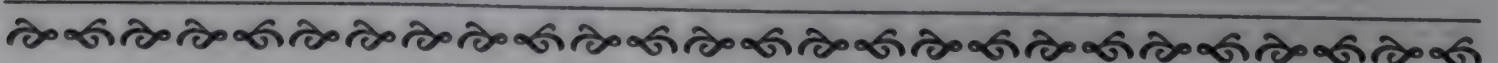
1. The facilitator asks the participants to form pairs

Each pair discusses their personal experiences of adolescence, with respect to one of the following aspects, with each other. (15 minutes)

- First menstruation (first experience of ejaculation or masturbation or night emission for men), feelings associated with it and reactions of others
- Bodily changes and feelings associated with it
- Relationship with parents and siblings (expectations and conflicts)
- Freedom and restrictions
- Friendship and peer pressure
- Friendship with opposite sex
- Dressing and role models
- Decision about studies/career chosen

The pairs share their experiences in the larger group (45 minutes—each pair 5 minutes) highlighting feelings, reactions of people around and expectations from others

At the end of the sharing the facilitator draws out the salient features of the nature and behaviour of adolescents and emphasises on the need for special skills to work with adolescents.



Facilitator's Note

Make sure that participants do not repeat to others what they shared in their pairs. They have to focus on their feelings during adolescence, reactions and expectations of people around them.

Points to Emphasise

- Adolescence is a phase of rapid physical and emotional changes.
- Girls and boys have a range of special needs during this phase — social needs, health needs, sexuality related needs, emotional, educational and career guidance needs.
- We need to be especially sensitive to needs of adolescents and develop skills to keep communication going with them.

Session 2 Health and Information needs of Adolescents

Learning Objectives

At the end of the session the participants will be able to

- list common, general and reproductive health problems of adolescent girls.
- know what are the specific health information needs of adolescents.
- analyse the needs of adolescent girls having reproductive health problems and list the role of health care providers in terms of sensitivity and skills to work with them in an OPD setting.

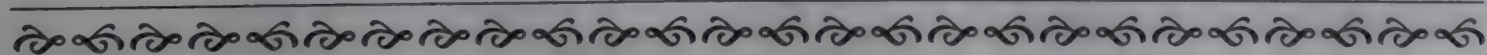
Time 1 hour

Resources

- Black board, chalks
- Handout 9. 2 FAQs by adolescent girls
- Handout 9.3 Episodes of adolescent girls visiting the Gynaecological OPD

Methodology

1. Divide the participants into four groups
- Each group discusses the following aspects and make presentations to the larger group.
- Common health problems (general and reproductive) occurring during adolescence (can also share their own personal problems as they remember them or those of their adolescent children)
 - What social factors underlie these health problems.
 - What are the likely ways of addressing and solving them.
 - Read the episodes of client provider communication (Handout 9.3) and list down role of health care providers in terms of addressing the needs of the adolescent in the case studies.



Facilitator's Note

The participants are encouraged to share their own experiences.

Points to Emphasise

- Girls have a range of information needs related to their bodies and health.
- Girls need time to talk about their problems, health care providers need to be gentle and patient while dealing with adolescent girls.
- They need explanation of what an examination entails.
- They need to be allowed time to ask their questions and seek reassurance from health care providers.

Session 3 Practicing the skills

Learning Objectives

At the end of the session the participants will be able to

- take the history of the adolescent girl in a sensitive and effective way
- provide basic counselling services to the adolescents visiting the OPD

Resources Copies of case studies for role play

Time 2 Hours

Methodology

1. Participants are divided into three groups

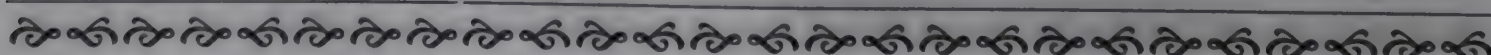
Each group is given a case study; they plan a role-play of the counselling session

Case 1

A 16 year old girl comes with her mother to the health care facility. Her mother tells the doctor that she is having excessive white discharge. The discharge is thin, watery having no smell. There is itching. She gets the white discharge just prior to menses. She is having the problem since last six months. She has discontinued her schooling after she failed in tenth standard. She stays at home and helps her mother in household chores. Her menstrual cycle is normal. Doctor finds no pathological cause and sends them to you for counselling.

Case 2

18-year-old Surekha comes to the hospital for MTP. Doctor confirms the pregnancy. She is not married. Her parents do not know about it. Her boyfriend has left her after knowing that she is pregnant.



Case 3

17-year-old girl comes with the complaint of itching in vaginal area and foul smelling white discharge. She is in a relationship with a boy in her community. Her mother does not know about this.

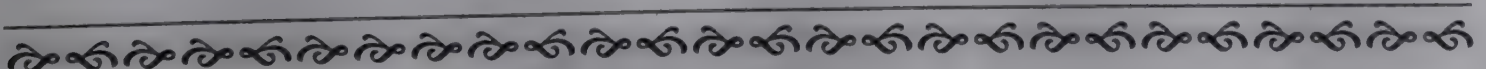
2. Each group presents the role plays and the facilitator and other participants give feedback emphasising the following points
 - Communication Skills
 - Privacy
 - Sensitivity
 - Confidentiality
 - Knowledge
 - Woman centred and gender sensitive counselling
3. Facilitator summarises the needs of the adolescent in counselling for reproductive health problems, based on the contents of the handouts and the principles of woman centred counselling.

Facilitator's Note

Affirm the developing communication and counselling skills of participants in the role plays. Since this is the last session in this module, focus on summarising the contents of the entire module.

Sources

Adolescent Girls' Initiative, Mumbai, Amita Abichandani, Rohini Gorey, Vidula Patil



HANDOUT 9.1**UNDERSTANDING ADOLESCENCE**

According to the WHO, "Adolescence is defined both in terms of age (spanning the ages between 10 and 19 years) and in terms of a phase of life marked by special attributes. These attributes include:

1. Rapid physical growth and development
2. Physical, social and psychological maturity, but not all at the same time
3. Sexual maturity and the onset of sexual activity
4. Experimentation
5. Development of adult mental processes and adult identity
6. Transition from total socio-economic dependence to relative independence."

Stages of Development during Adolescence

Although researchers have defined and differentiated the stages of adolescence in different ways, all definitions clearly indicate that the following changes occur during adolescence—

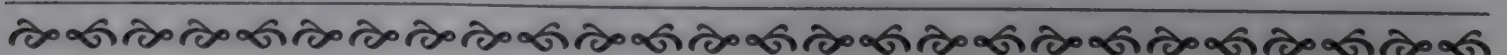
1. Biological development in bodily size and shape
2. Cognitive development
3. Developing self-concepts and self-esteem
4. Relationships with family, peers and society
5. Sexuality and moral development

Bodily Changes on the onset of Puberty in Boys

1. Increase in height, weight and muscles
2. Deepening of voice due to larynx (voice box) growth
3. Skin becomes oilier; appearance of pimples on face, neck, chest and back due to activation of sebaceous oil glands
4. Increase in production of sweat
5. Appearance of pubic and facial hair
6. Penis and testicles enlarge in size
7. Development of testes and production of sperm accompanying first ejaculation
8. Having strong sexual feelings

Bodily Changes on the onset of Puberty in Girls

1. Growth in height and weight
2. Widening of hips
3. Increase in size and shape of breast



4. Appearance of pimples due to oily skin and activation of sebaceous oil glands
5. Tendency to sweat more
6. Under-arm and pubic hair growth
7. Maturing of ovaries, uterus and vagina
8. Beginning of menarche
9. Romantic and sexual feelings

Sub-stages of Adolescence

Adolescence is generally divided into three sub-stages of development. The phase prior to onset of puberty and adolescence is known as pre-pubescence or pre-adolescence. The person is not yet aware of his/her sexual identity and is learning to master social skills and spend more time with the family. Adolescence is divided in the sub-stages as :

1. Early adolescence
2. Middle adolescence
3. Late adolescence

Studies available on adolescents suggest that adolescents exhibit different characteristics during these sub-stages. Due to considerable overlapping of characteristics, these sub-stages cannot be demarcated distinctly. These sub-stages are -

Early adolescence (11-13 years)

The stage is marked with the appearance of secondary sex characteristics along with rapid physical growth. The characteristics of this stage are:

1. Self-awareness regarding physical appearance; self-consciousness increases
2. Self-esteem may increase/decrease due to parent or peer influences
3. Emotional, impulsive, moody behaviour
4. Risk-taking and adventure prone
5. Movement away from family towards peers
6. Unequal gender role distribution, inequalities in power and prestige affect self-esteem
7. Increased socialisation among same sex groups
8. Advances towards opposite sex
9. Initiate sexual exploration
10. Dilemma regarding initiation and engagement in sexual activities

This stage also marks the beginning of formal operational stage of Piaget's cognitive development theory and cuts across the age of eleven years and above. The adolescents develop their ability for abstract thinking and can "operate on operations" as compared to the previous stage children who can only "operate on reality" (Berk, 2001). The other aspects of development are-

11. Development of hypothetico-deductive reasoning capability
12. Formal operational egocentrism, that is, inability to distinguish abstract perspectives of self and others
13. Propositional thought formation, that is, the ability to propose options/alternatives
14. Development of perspective taking, that is, the capacity to imagine what other people may be thinking and feeling

Middle adolescence (14 – 16 years)

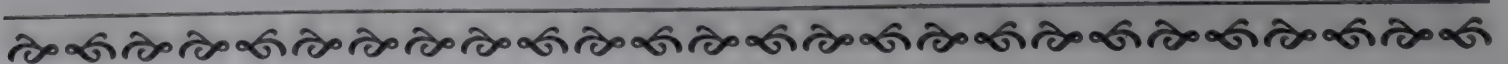
Middle adolescence brings dramatic changes in adolescents due to biological maturation and social pressure. The adolescents start developing a variety of social-cognitive skills, which help them to deal with stresses of everyday life and improve attitude towards school. They are also able to solve conflicts and problems. Common characteristics of the stage are –

1. Physical and sexual maturation continues
2. Desire to seek privacy and isolation
3. Identity formation; increased ability to evaluate beliefs of self as well as others
4. Growing distant from parents
5. Strong peer group bonding; peer influence on self-image and social behaviour
6. Development of personal code of ethics, values and beliefs
7. Family influences religious values, education, and career
8. Attraction towards opposite sex increases
9. Initial sexual exploration, grows into sexual experimentation
10. Masturbation

Late adolescence (16 – 19 years)

This stage calls for a higher level of understanding as adolescents become comfortable and are able to cope with the changes. The changes continue to occur and adolescents strive for a higher level of stability in life. Some of the features are:

1. Understanding oneself better; developing self identification
2. Making career and vocation choices for future
3. Becoming more reflective and responsible
4. Striving for balance between traditional and modern values
5. Conflict within self regarding acquisition of adult roles and responsibilities
6. Behaving according to social norms; greater social participation
7. Intimacy and commitment demanded in relationships
8. Peer influences lessen



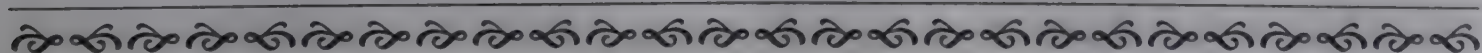
Needs during Adolescence

Adolescence has its specific needs. These include....

1. Social needs
2. Difficulty in interpersonal relationship especially, communication with opposite sex
3. Fantasy vs. reality
4. Adjusting with environment – growing into adulthood from childhood
5. Facilitating smooth adolescent-parent relationship
6. Health needs
7. General health needs for diseases
8. Physical body changes at puberty
9. Personal health and hygiene
10. Sex and sexuality needs
11. Counseling services for issues of sex, masturbation, sex abuse, etc.
12. Family life education and/or sex education in schools
13. Emotional needs
14. Adjustment with changing self
15. Mastering emotional stability
16. Emotional involvement/attachment with opposite sex
17. Educational/Career needs
18. Counselling and guidance
19. Inferiority complex due to poor performance
20. Adjusting with fellow students and environment
21. Coping with educational/professional stress

Source:

Women's Health Training Research Advocacy Cell (WOHTRAC, 2003, January). Peer Education Strategy to Build Life Skills of Adolescents for Healthy Living. Vadodara.



HANDOUT 9.2

WHAT ADOLESCENT GIRLS WANT TO KNOW

Frequently Asked Questions regarding their Bodies and Health

Body Image concerns

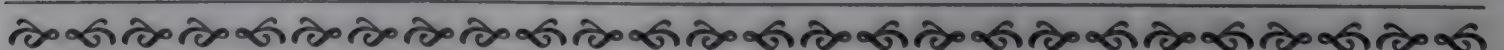
1. How can one reduce weight?
2. Can we lose weight by not eating on certain days in a week?
3. How should we take care of our body?
4. What should we do if our weight is not increasing?
5. What causes acne? How can we be rid of them?
6. What can we do to become good looking?
7. How should we take care of our face and hair so that they keep looking good?
8. Does waxing body hair affect our skin?
9. Is it possible to increase or reduce the size of our breasts?

Diet and Nutrition concerns

10. What kind of food is harmful?
11. Why do we eat fruit and vegetables?
12. What kind of food should we eat to reduce weight?
13. What is a balanced diet, how is it beneficial?
14. From which foods do vegetarians get protein?
15. If one does not like milk, what should one do?
16. Is there an age from which one can start drinking tea or coffee?
17. What type of meal should we take to reduce our weight?

Menstruation concerns

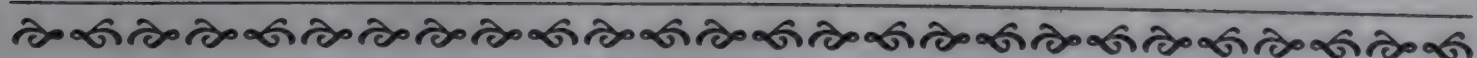
18. Why does menstruation occur? What causes menstruation?
19. At what age should menstruation occur?
20. Some girls start menstruation at a later age, why?
21. What is ovary and where is it? How does it function?
22. If a girl does not start menstruating, does it mean she can not have a baby?
23. Why do we have stomach ache, backache or nausea during periods? Is it normal?
24. Is it harmful if the periods continue for more than five days?
25. Is it harmful if the bleeding stops after one day?
26. How much bleeding is normal?



27. If one takes medicines to start one's periods, can it cause any problem in the future?
28. If a girl does not get periods regularly or does not get it for 5-6 months, what should she do?
29. Do irregular periods cause weight gain?
30. How do we come to know that we will have periods? What are the signs?
31. How do we maintain cleanliness during periods?
32. What is better, using cloth or sanitary pad?
33. Why do older women not have periods?
34. Can we eat pickles in the time of periods?
35. Is it alright to touch others when we have periods?
36. What kind of exercise should we do during periods?
37. They say one should not talk to boys during periods, is that right?

Sexual and Reproductive Health concerns

38. Why does hair grow on our private parts?



HANDOUT 9.3

EPISODES OF ADOLESCENT GIRLS VISITING THE GYNAECOLOGICAL OPD

Episode 1:

This episode is documented by an observer who was observing client provider communication in a gynaecology OPD in a general hospital

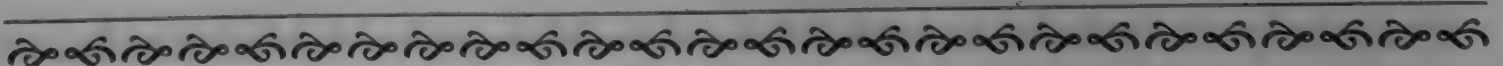
A young girl walked in with a new and an old case paper in her hand. The observer recognized her. She smiled at the observer. She had come yesterday but because she was late she was sent away.

- Dr. : What has happened? What is your problem? *Kya hua hai?*
- Patient : I have a growth/ lump in my genital area. *Mereko na gaanth aaya hai pishab ki jagah*
- Dr. : What is your age? *Apka umar kya hai ?*
- Patient : 19. *Unnis*
- Dr. : Since when do you have this? *kabse aaya hai?*
- Patient : About 4 months. Earlier it was small. I showed it to a doctor near where I live and he said it is nothing, it will go away. Now that it has become bigger, he said that I should go to the big hospital. *Ho gaya chhar mahina. Pahale chhota tha, maine hamare yeha doctor ko Dikhaya tha, woh bola, kuchh nahi, chala jaayega. RI bada ho gaya to woh bola abhi bade aspatal mein jaake dikhao.*
- Dr. : Okay. Are your periods regular? *Thik hai, mahina barabar aata hai?*
- Patient : Yes. *ha*
- Dr. : You are not married, are you? *Shadi nahi hua hai na ?*
- Patient : No. *nahi* (she smiled and looked down)
- Dr. : Okay, take this paper and sit down there. *Accha, yeh paper leke waha baitho*

The girl was then examined on the examination table by two students . They could not figure out what it was. The girl was not opening her legs properly. So the observer told her to open up properly for the doctor to see.

Suddenly the two student doctors left without telling her anything. The girl climbed down from the table and asked the observer whether she can wear her underclothes. The observer went and asked the students and they said no, because they wanted the RMO to examine her. Then the other doctor went in. The girl had almost got down from the table not knowing what to do. Seeing the doctor she again lay on the table.

After the examination the doctor came out and sat down. The girl came out of the examination room with her paper. Doctor wrote the medicine on her paper and told her to take the medicine and return after two weeks. Another patient came in between and showed her paper to the doctor.



Doctor : (Hurriedly) take these tablets. *yeh goli lena.*

The girl did not go away. She just stood there. Maybe she wanted to ask or know something more.

Patient : Nothing else needs to be done? *Aur kuchh nahi karneka?*

Doctor : (In an irritated tone) No, nothing else is required. *Nahi, Aur kuchh nahi.*

The girl left the OPD.

Episode 2:

On the same day an adolescent girl had come to the OPD. She too was reluctant to let the male doctor examine her. The doctor explained to her what the examination was about, what he would learn from the examination and why it was necessary. He also assured her that it would not hurt her and sensing that she was feeling shy he asked one patient he had examined to tell the girl how it felt during the examination. That patient told the girl that it doesn't hurt, doesn't take much time and whether the doctor is male or female doesn't make much difference. The doctor then gave the girl some time to think and then asked her if she was willing for examination. The nurse and the sweeper also told her that since she had waited so long in the OPD she should undergo examination. The doctor had spent almost 15 minutes explaining to her.

Domestic violence is defined as physical, emotional or economic violence done on women either by their husbands or other members of the family, within the home. Domestic violence is also termed as family violence. Gender based violence is a broader concept. It is defined as any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such act, coercion or arbitrary deprivation of liberty whether in public or private life (WHO).

Domestic or Family Violence is one category of gender based violence. Other categories of gender-based violence are those occurring due to

- Traditional and cultural practices, for example branding women as *dakins*, *dayans* or witches in certain societies, violence on widows - abandonment, food, taboos, social isolation etc.
- torture and rape of detained women in custody.
- armed conflict and displacement. In times of caste, communal and ethnic conflict, women's bodies are perceived as "territory to be conquered" and violence against women is used to increase men's subjugation and humiliation
- forced prostitution and trafficking.
- sexual harassment at public places and work places, e.g. burns inflicted on girls by unwanted lovers, date rapes and so on.

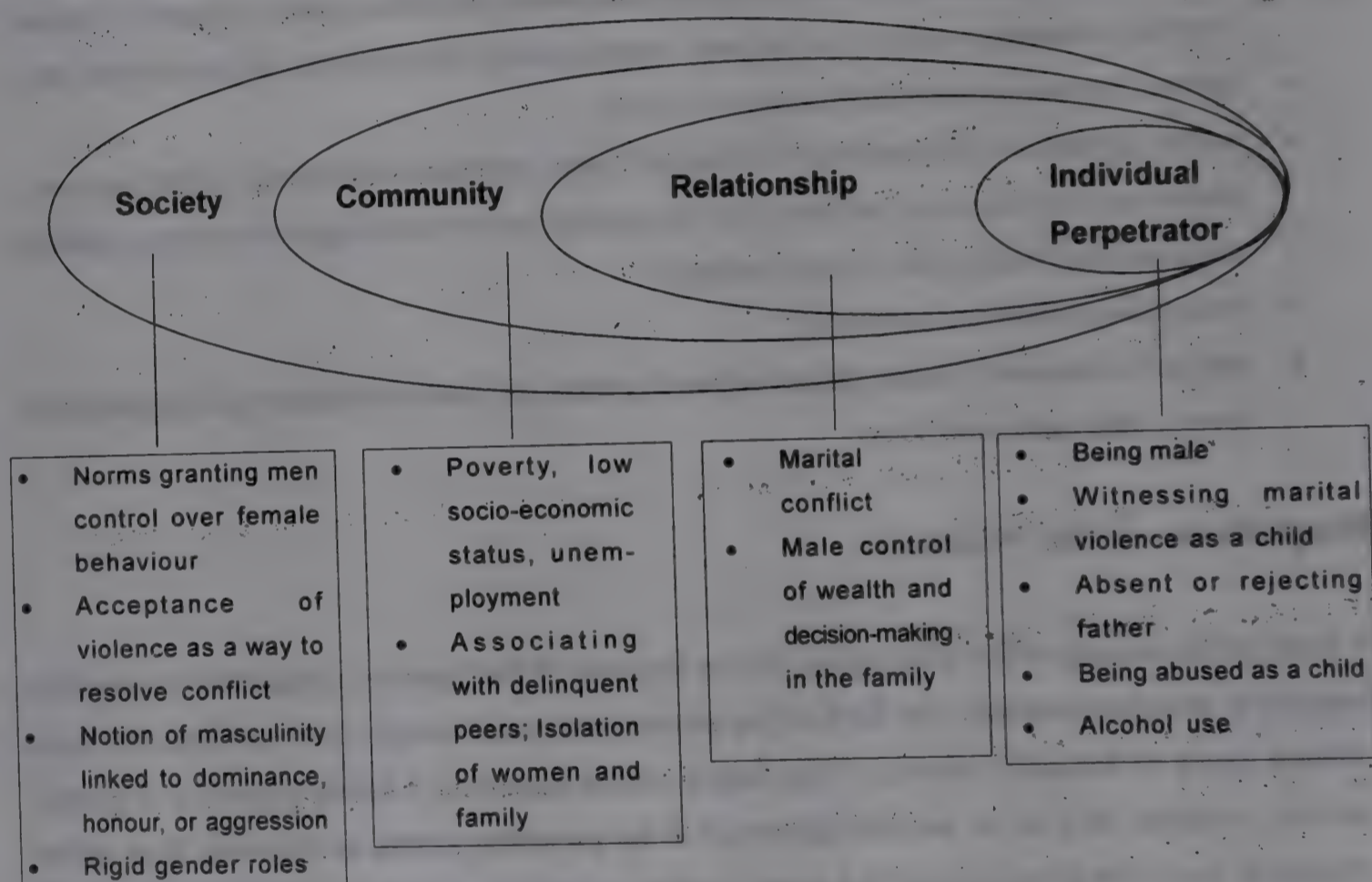
Magnitude of the Problem

A study of the records in the Emergency Police Register of the Casualty Department in a public hospital in Mumbai revealed that 23% of the women who were brought into the Casualty were definite cases of domestic violence. They had suffered assault by a family person or a 'known person'. Another 44% of all women appeared to be possible victims of violence; they either refused to name the perpetrator of the assault (19%) or attributed the burns that they suffered to accidental stove burst (9%), or were cases of attempted suicide, a measure to which women who have suffered violence and harassment are likely to resort (16%). Thus up to two-thirds of women reporting to the casualty department may have suffered domestic violence (Daga et al. 1998). Observations of client-provider communication in a Gynaec OPD, interviews with patients in the OPDs indicate that there are incidents of domestic violence which go undiscussed and unreported even within the hospital situation. (WCHP, 2000)

Ecological Model of Violence

Lori Heise describes an ecological framework to understand the interplay between personal, situational and socio-cultural factors that cause gender-based violence and abuse. This model can best be visualised as four concentric circles. The innermost represents the biological and personal history that each individual brings to his/her behaviour in personal relationships. The second circle represents the immediate context in which abuse takes place - often the family or other intimate and close relationship. The third circle represents the institutions and social structures, both formal and informal, in which relationships are embedded i.e. the neighbourhood, work place, peer group. The outermost circle is the social and economic environment, including cultural norms.

Ecological Model of Factors Associated with Partner Abuse



(Source : Lori Hiese, 1994)

This framework can be used in counselling victims of gender-based violence. Using the framework to analyse her situation, with her, can help the woman develop appropriate strategies.

Violence is a result of power inequalities. The perpetrator generally has physical power as well as power based on authority resulting from access to, and control over, resources. The victim of violence is relatively powerless in terms of control over resources of any kind - economic, material, and psychological. Violence against women is an essential part of the patriarchal ideology and structures of domination and exploitation of women in society. Patriarchy, which means the rule of the father,

vests in men's control over economic and material resources. Women are considered a part of men's property and thus men have control over women's productive power, reproductive capacities and sexuality. Rape and the threat of rape is a significant way by which men control women's sexuality.

Violence against women is a violation of their human right. Sex selective abortions deny the female sex the right to exist. Right to bodily integrity is denied through physical violence. Their right to dignity is violated when they are subjected to degrading and inhuman treatment and mental torture.

Thus addressing violence against women, through counselling and other interventions, are acts that uphold human rights of women.

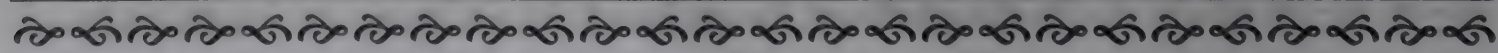
Health Consequences of Violence

The health consequences of violence range from non-fatal outcomes that have impact on physical and mental health, to fatal outcomes like suicide, homicide, maternal death and HIV/AIDS. Among the physical health consequences are injury (lacerations, fractures and internal organ injuries), unwanted pregnancy, gynaecological problems, STDs including HIV, miscarriage, pelvic inflammatory disease, chronic pelvic pain, headaches, permanent disabilities, asthma, irritable bowel syndrome, and self-injurious behaviour like smoking, unprotected sex. The mental health outcomes are depression, fear, anxiety, low self-esteem, sexual dysfunction, eating disorders, obsessive-compulsive disorder and post-traumatic stress disorder. Violence against women is a major public health concern and should be a priority for the health sector because it causes immense suffering and negative health consequences for a significant proportion of the female population. The costs of violence against women are tremendous, not only for the individual but also to society in terms of providing medical care and legal services (Heise et al., 1994).

Health consequences of violence against women	
Non-fatal outcomes	
Physical health outcomes	Mental health outcomes
<ul style="list-style-type: none"> • Injury (from lacerations to fractures and internal organ injuries, Burns) • Unwanted pregnancy • Gynaecological problems • STDs including HIV • Miscarriage • Pelvic inflammatory disease • Chronic pelvic pain • Headaches • Permanent disabilities • Asthma • Irritable bowel syndrome • Self-injurious behaviour (e.g. smoking, unprotected sex) 	<ul style="list-style-type: none"> • Depression • Fear • Anxiety • Low self-esteem • Sexual dysfunction (examples) • Eating problems • Obsessive-compulsive disorder • Post-traumatic stress disorder • Guilt, loss of self-confidence and self-esteem
Fatal outcomes	
<ul style="list-style-type: none"> • Suicide • Homicide • Maternal death • HIV/AIDS • Phobias • Psychosomatic disorders 	
<p>(Source : World Health Organisation, (2000) Health Impact of Violence Against Women, WHO Regional Office for South-East Asia; Women of South-East Asia: A Health Profile, WHO, New Delhi).</p>	

The health care system and health workers are in a unique position to identify, document and respond or refer victims of violence, because they are the first contact point for persons who have been assaulted, as they will seek medical assistance for their injuries, even if they do not disclose the violent incident. The health care providers can provide comprehensive, gender-sensitive health services to victims of violence to manage the physical and mental health consequences of the assault.

The health system has to recognize violence against women in the different situations outlined above and have different strategies for addressing each situation. For instance, in situations of armed conflict and in refugee camps, the health services which are already over stretched, need to recognise rape and sexual abuse and be prepared to deal with the trauma associated with it. Health services in or near red light areas have to deal sensitively with the incidents of violence against sex workers.



A WHO consultation on violence against women in 1996 identified the following as issues to be addressed so that the health care system can be more responsive to women victims:

- providers' negative feelings (e.g. health personnel may feel inadequate, powerless and isolated, especially in areas with few referral services)
- cultural beliefs (e.g. violence by partners is a private or family matter)
- beliefs about victims (e.g. women provoke violence, women are able to stop violence by changing their behaviour, most women who stay with their partners have masochistic tendencies) (World Health Organisation)

Health care providers generally seem to believe that the causes of physical injuries that battered women present with are not their business. They perceive their role as limited to dressing the wounds, and prescribing medicines. Some view domestic violence as a private issue and fear that clients would be upset or offended if asked directly about violence. Others do not quite know how to ask and how to respond if a woman does admit to being abused. Yet others feel that they have no time to spare (within the context of overcrowded dispensaries and out patient departments) to deal with the needs of victims of violence.

Another barrier to health workers addressing violence is that they belong to the same cultural and social milieu as their patients. They share the values and attitudes towards abuse that are prevalent in the larger societal context. For instance, many women and men believe that a woman is the property of her husband and so an occasional beating is quite acceptable. Or the constructs of sexuality in many cultures define that women have to be available for sex whenever their husbands 'need' it. Male clinicians may hesitate to accept a woman's account of violence because they identify with the offender. Female health workers who have been victims of abuse may not find it easy to discuss violence with their patients.

Another major barrier to health workers addressing violence against women in India is that these are medico-legal cases and doctors are reluctant to get involved in legal liabilities and procedures. Lack of referral services and poor coordination between health, legal and social welfare departments also act as a deterrent.

What do women victims of violence consider as supportive behaviour on the part of health care providers? Studies have shown that battered women value direct questions about abuse, referrals to appropriate agencies that offer assistance, follow up and non-judgmental support (WHO, 2000). According to women in a Wisconsin Study, unsupportive behaviour on the part of physicians included neglecting to ask how an injury occurred, not taking a history of violence, not asking about the safety of children, and failure to refer them to support services and to schedule a follow up visit. The following were listed as desirable supportive behaviours:

Medical support

- Taking a complete history
- Detailed assessment of current and past violence
- Gentle physical examination
- Treatment of all injuries

Emotional support

- Confidentiality
- Directing the partner to leave the examination room
- Listening carefully
- Reassuring the woman that abuse is not her fault and validating her feelings of shame, anger, fear and depression

Practical support

- Telling the patient that spouse-abuse is illegal
- Providing information and telephone numbers for local resources such as shelters, support groups, legal services
- Asking about children's safety
- Helping the patient begin safety planning
- Scheduling a follow-up visit.

Indicators of Gender-based Violence for Health Care Providers

Women's organisations and other groups working with health care systems on gender based violence have identified some indicators which can serve as warning signals to health care providers in clinics and hospitals.

Warning Signs for Health Workers

- A woman who makes an appointment but does not attend.
- A woman with multiple injuries in places that are usually covered by clothing.
- A woman whose partner comes with her and stays close at hand in order to monitor what is said.
- A woman with evidence of strangulation attempts on the neck or fractures to the upper arms, which may have been caused when the woman tried to defend herself.
- A woman who is excessively shy, embarrassed or anxious, or who is reluctant to provide information about how she was injured.
- A woman or partner with a history of psychiatric problems such as depression, alcoholism, drug abuse or suicide attempts.
- A woman with a history of "accidents".
- A woman, particularly if pregnant, with injuries to the breasts, genitalia or abdomen.

(Source: 'The Intimate Enemy: Gender Violence and Reproductive Health' in *Panos Briefing No. 27, March 1998.*)



The semiotics of domestic violence

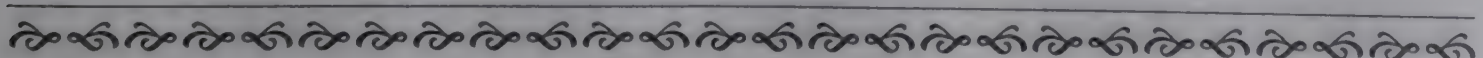
Symptoms of violence	Signs of violence
<p>Sensations and/or pains that women manifest that can often be attributed to violence :</p> <ul style="list-style-type: none"> • Minor or severe trauma that produces noticeable bruises on the body, especially around the eyes and face • Injuries produced by blows or by sharp objects • Loss of teeth, often associated with maternity or malnutrition, can also be caused by kicks or blows to the mouth • Deformation of the nose produced by fractures of the bridge, even when the result of earlier injuries often permits a diagnosis of current violence • Frequent nosebleeds, for which women seek treatment, can in fact be produced by aggressions • Leucorrhoea, or vaginal secretions, caused by trichomoniasis or other STDs, can frequently be signs of sexual violence • Vaginal haemorrhages produced by mistreatment of women, whether or not pregnant 	<ul style="list-style-type: none"> • Women who are anxious, fearful, sad, dispirited • Women who are aggressive without apparent cause • Prematurely-aged women • Dejected, humble women who express worthlessness or refer to themselves as stupid or incapable • Women who complain of unspecified pains, muscle contractions, numbness, intestinal or pelvic pains • Women with frequent headaches or insomnia • Women who complain of pain or experience no pleasure during sex or consider it a sacrifice. Expressions such as the following are typical of women subjected to frequent violence : "He uses me". "He relieves himself with me". "This is the cross you bear in marriage". "It's a woman's martyrdom".

(Source : World Health Organisation, Health Impact of Violence against Women, WHO Regional Office for South-East Asia; *Women of South-East Asia: a Health Profile*, WHO, New Delhi, 2000).

Counselling for Violence

The most important question that we are faced with today is - **How do you get a woman to speak about her issues related to violence?** Many factors could be responsible for a woman's unwillingness to speak about her issues and more so when it involves violence in any form, and here is where counselling plays a very important role.

A woman who is a victim of violence, first and foremost needs to be assured of her safety. By providing her privacy and confidentiality, a space is created wherein a violence victim feels safe to reveal the details of her problem. A woman who has been in an abusive relationship will be psychologically upset - she may be afraid, anxious, insecure, angry, confused. The counsellor needs to have patience and help the woman by naming her feelings, by reflecting back to her what she is expressing. The counsellor has to convey upfront that violence is not merely a 'private' or 'family matter' - it is a serious socio-political problem and violence of any kind is unacceptable. The counsellor has to validate the woman's feelings and relate them to the larger context, as similar to those stemming from struggles against oppressive social and political structures.



It does not help the woman, if we as counsellors say anything that will indicate that we blame her for her situation, for example, 'Couldn't you see how he was blackmailing you?' or 'Why did you stay on so long?' Such questions will further disempower her. As counsellors we need to find ways by which we can help her to feel a sense of power and control and to handle even small decisions on her own. Counsellors should be careful that they do not reinforce existing gender stereotypes or sexist beliefs, for example 'yes, as women we are so emotional!' or 'what can you do around the house, or for him that will prevent him from becoming violent?'

It is important to help the woman identify who she can rely on for various kinds of help next time there is an episode of violence. It is important to help the woman prepare a safety plan. A few do's and don't's of a safety plan therefore would be as follows:

Do's :

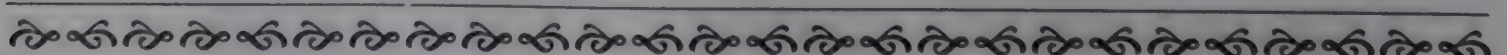
- ask
- express concern
- listen and validate
- offer help
- support her decisions

Dont's :

- judge or blame
- wait for her to come to you
- pressure her
- give advice
- place conditions on your support

Here are a few steps that could be suggested to a woman and her children for their safety:

1. Practice getting out of your home safely. Identify which window, or door would be best.
2. Whenever you believe that you are in danger, leave your home and take your children, no matter what hour of the day it is. Go to a friend or relative's house or a domestic violence shelter.
3. Devise a code word to use with your children, family, friends and neighbours when you need the police.
4. Plan where you will go if you have to leave home, even if you think you will not need to.
5. Have a packed bag ready and keep it in a secret but accessible place so that you can leave quickly.
6. Identify neighbours you can tell about the violence and ask them to call the police if they hear any disturbance coming from your home.



7. When an attack has begun, escape if you can.
8. Call for help, scream loudly and continuously. You have nothing to be ashamed of - the batterer does.
9. During an argument stay close to an exit and avoid being near the kitchen or anywhere near weapons.
10. Defend and protect yourself. Seek medical assistance for your injuries.
11. Trust your own instincts and judgment. Whatever you need to do to survive, is the right choice. You have the right to protect yourself.

Module Objectives

At the end of this module, the participants will

- recognize that GBV is a serious socio-political problem and has health consequences for women.
- describe their role in addressing GBV
- acquire skills in identifying victims of violence in the clinic/hospital and when to refer to more specialised counsellors.

Session 1 Personal Experiences of Gender-based Violence

Learning objectives

At the end of the session the participants will

- recognize that GBV is not only a personal problem but also a serious socio-political problem

Time 1 hour

Resource Flip chart and marker pens, OHT 10.1

Methodology

1. Group Discussions for 30 minutes on
 - a. (i) Where have we encountered GBV in our own lives personally?
 - (ii) What are the obstacles to our addressing GBV?
 - b. (i) where have we encountered GBV in our professional lives
 - (ii) what are the obstacles to addressing it?
2. Group presentations
3. Facilitator highlights that GBV is a problem of epidemic proportions using OHT 10.1. It is not merely an individual, clinical problem but has its roots in larger socio-political structures in which health care providers have an important role to play in addressing GBV and the ways in which obstacles can be addressed.



Session 2 Cycle and Models of Violence

Learning Objectives

- At the end of the session the participants will be able to
- relate the incidences of violence to the concepts and the framework of gender based violence

Time 90 minutes

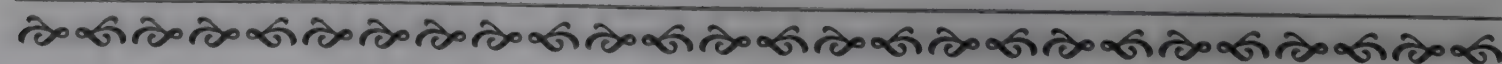
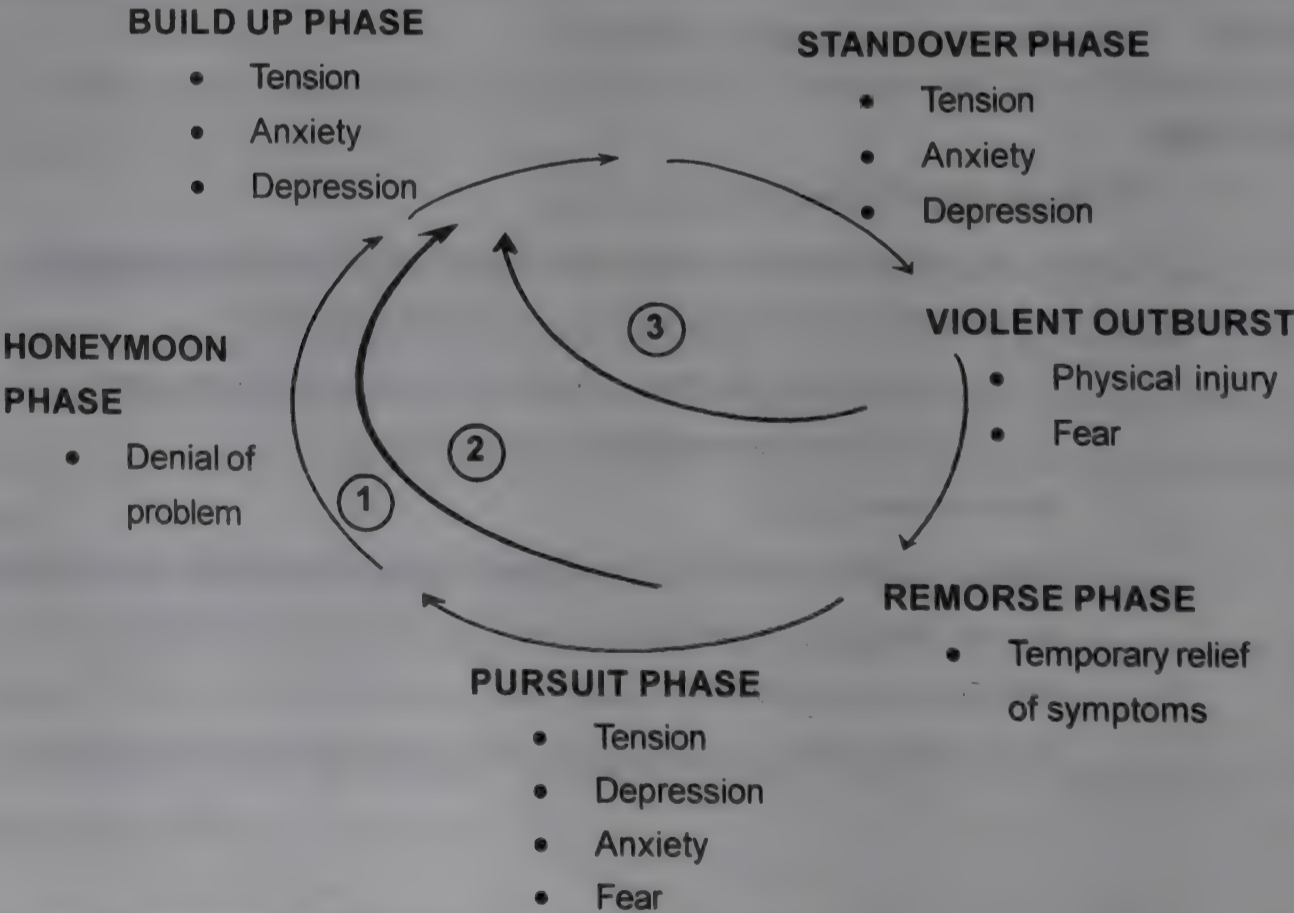
Resources OHT 10.2 and 10.3 on the Cycle of violence and Ecological framework of violence

Methodology

1. The facilitator conducts brainstorming session on What is Gender based Violence.
 - Facilitator gives presentations of
 - Cycle of Violence and
 - Ecological Framework for Violence
2. Has a discussion of these models, invites questions, reflections.
3. Facilitator leads the discussion to
 - Psychological state of the abused woman
 - Reasons why a woman continues in an abusive relationship with or without seeking help

Why does a woman continue in an abusive relationship?

- She thinks he'll change, he's basically a good man
- If she is a 'good' wife, her love will be powerful enough to change him
- 'It is the duty of a wife to stick by her husband regardless of what may happen'
- Economic reasons
- No support from natal family
- For the sake of the children



Session 3 Violence and Health

Learning Objectives

At the end of the session participants will be able to

- understand the types of violence and its consequences on the life and health of the victim
- know where to refer cases of violence that come to the Gynaecology OPD

Time 1 hour 30 minutes

Resources Chart papers and markers, OHT 10.4 Health consequences of Violence

Methodology

1. The facilitator conducts brainstorming session on whether and how GBV is health issue
2. The participants are then divided into three groups. Each group is asked to discuss type of violence, its physical, social and psychological effects on the victims in the following situations
 - At home
 - At the work place or outside home
 - As a personal identity (like daughter, wife, married/ unmarried, widow, divorcee, separated, deserted, childless etc.)
3. The groups then make the presentation to the larger group.
4. Facilitator summarises by showing OHT 10.4

Session 4 Screening Victims of GBV

Learning objectives

At the end of the session, participants will be able to

- ask appropriate questions for screening possible victims of violence
- Identify signs and symptoms of violence

Time 1 hour

Resources OHT 10.5 on Warning Signs and Symptoms of Violence

Methodology

1. Group Discussion for 30 minutes on
 - How can we tell whether a woman has been possibly abused?

- What sort of questions can we ask to identify victims of GBV?
2. Group presentations

Facilitator's Note

Facilitator sums up the group reports. Also cautions about the need to be sensitive and observant and the danger of transgressing boundaries and being invasive. Facilitator ends session by showing OHT 10.5 and 10.6 on 'warning signs' and 'signs and symptoms'.

Session 5 Devising a Safety Plan

Learning Objectives

At the end of the session, participants will be able to

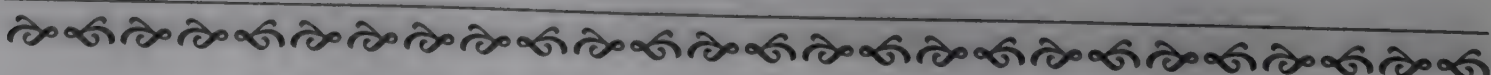
- prepare a safety plan for victims of repeated violence
- identify support systems in the immediate environment of the victim

Time 30 minutes

Resources OHT 10.7 and 10.8 on Do's and Don'ts and Devising a Safety Plan

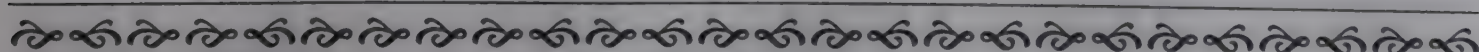
Methodology

1. Participants will form pairs and discuss
 - (i) What would they do to ensure the safety of a woman who is facing repeated episodes of violence (5 minutes)?
 - (ii) List the resources (people and institutions) that they could mobilise/contact to help this woman (10 minutes).
2. Share in the larger group (15 minutes).
3. The facilitator lists the responses and summarises by using OHT 10.7 and 10.8 on Do's and Don'ts and Devising a Safety Plan.



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OVER-HEAD TRANSPERENCIES

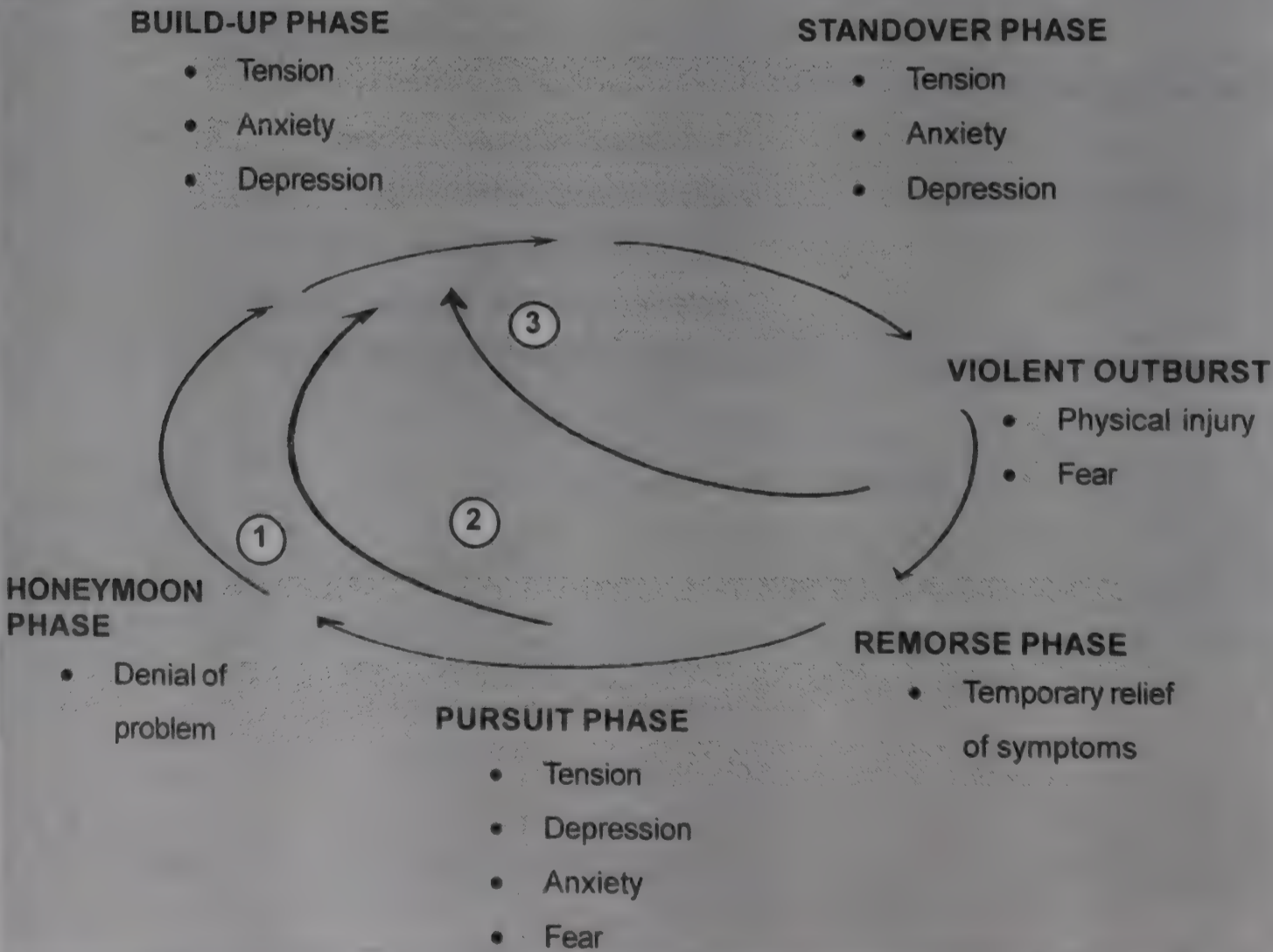
OHT 10.1

MAGNITUDE OF GENDER BASED VIOLENCE

- 1 in every 5 ever married women experienced domestic violence (NFHS, 1998 – 99)
- 1 in every 9 women reported being beaten in the last 12 months (NFHS, 1998 – 99)
- Largest single cause of death among women in 15 – 44 years age group is violence (burns, drowning, suicide, homicide 26.3%) (Maharashtra vital statistic handbook, 1996)
- Between 1991 and 1995 crimes against women increased by 45%. (Crimes in India, 1995)
- 66.7% cases coming to Emergency Dept. of a Govt. Hospital in Mumbai in 1996 were definitely or possibly due to violence (Daga et.al. 1998)

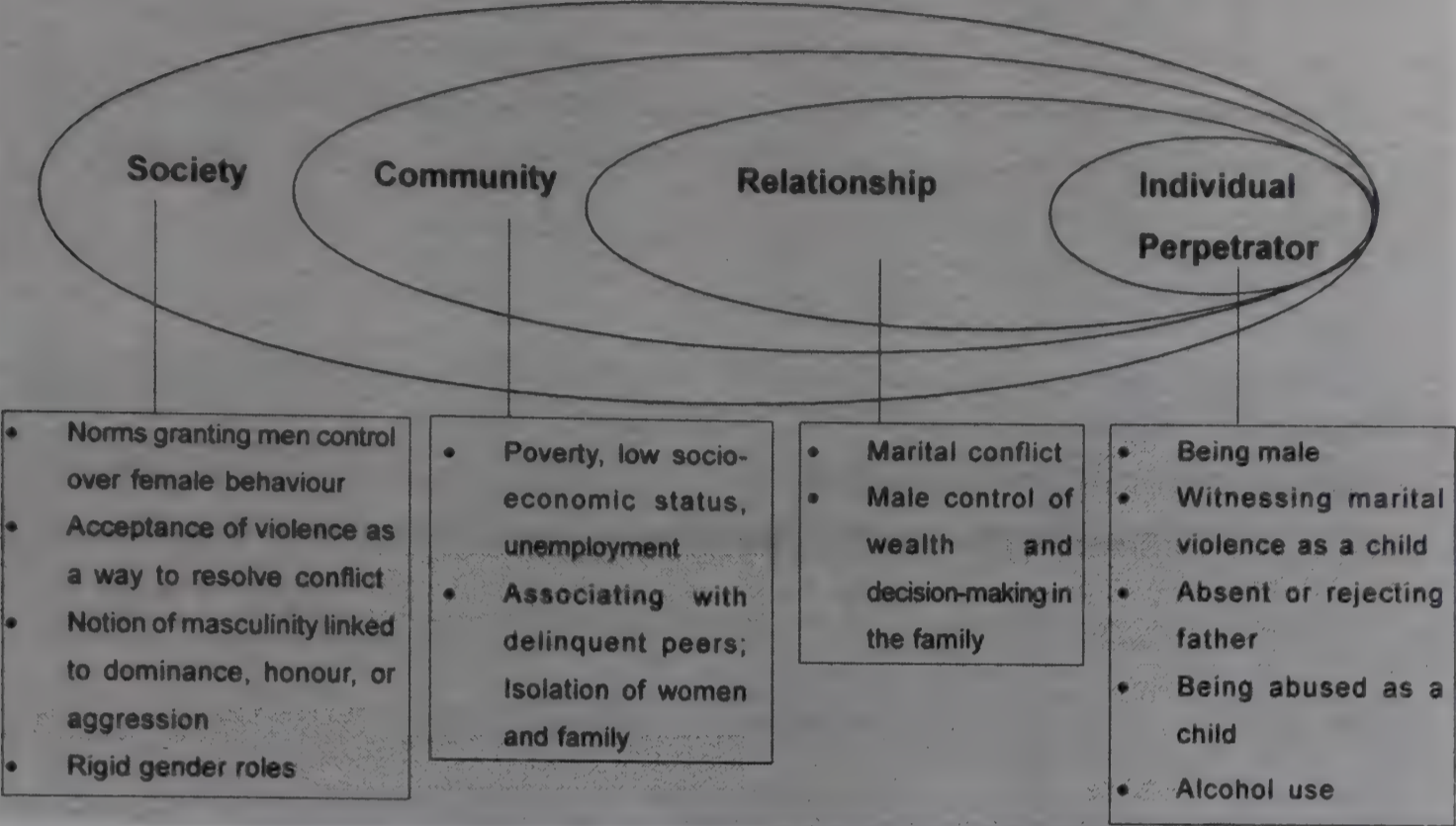
OHT 10.2

SHORTENING OF THE CYCLE OF VIOLENCE



OHT 10.3

ECOLOGICAL MODEL OF FACTORS ASSOCIATED WITH PARTNER ABUSE



OHT 10.4

HEALTH CONSEQUENCES OF VIOLENCE AGAINST WOMEN

Non-fatal outcomes	
Physical health outcomes	Mental health outcomes
<ul style="list-style-type: none">• Injury (from lacerations to fractures and internal organ injuries, Burns)• Unwanted pregnancy• Gynaecological problems• STDs including HIV• Miscarriage• Pelvic inflammatory disease• Chronic pelvic pain• Headaches• Permanent disabilities• Asthma• Irritable bowel syndrome• Self-injurious behaviour (e.g. smoking, unprotected sex)	<ul style="list-style-type: none">• Depression• Fear• Anxiety• Low self-esteem• Sexual dysfunction (examples)• Eating problems• Obsessive-compulsive disorder• Post-traumatic stress disorder• Guilt, loss of self-confidence and self-esteem
Fatal outcomes	
<ul style="list-style-type: none">• Suicide• Homicide• Maternal death	<ul style="list-style-type: none">• HIV/AIDS• Phobias• Psychosomatic disorders

OHT 10.5

WARNING SIGNS FOR HEALTH WORKERS

- A woman who makes an appointment but does not attend.
- A woman with multiple injuries in places that are usually covered by clothing.
- A woman whose partner comes with her and stays close at hand in order to monitor what is said.
- A woman with evidence of strangulation attempts on the neck or fractures to the upper arms, which may have been caused when the woman tried to defend herself.
- A woman who is excessively shy, embarrassed or anxious, or who is reluctant to provide information about how she was injured.
- A woman or partner with a history of psychiatric problems such as depression, alcoholism, drug abuse or suicide attempts.
- A woman with a history of "accidents".
- A woman, particularly if pregnant, with injuries to the breasts, genitalia or abdomen.

(Source: 'The Intimate Enemy: Gender Violence and Reproductive Health' in *Panos Briefing No. 27*, March 1998).

OHT 10.6

THE SEMIOTICS OF DOMESTIC VIOLENCE

Symptoms of violence	Signs of violence
<p>Sensations and/or pains that women manifest that can often be attributed to violence :</p> <ul style="list-style-type: none">• Minor or severe trauma that produces noticeable bruises on the body, especially around the eyes and face• Injuries produced by blows or by sharp objects• Loss of teeth, often associated with maternity or malnutrition, can also be caused by kicks or blows to the mouth• Deformation of the nose produced by fractures of the bridge, even when the result of earlier injuries often permits a diagnosis of current violence• Frequent nosebleeds, for which women seek treatment, can in fact be produced by aggressions• Leucorrhoea, or vaginal secretions, caused by trichomoniasis or other STDs, can frequently be signs of sexual violence• Vaginal haemorrhages produced by mistreatment of women, whether or not pregnant	<ul style="list-style-type: none">• Women who are anxious, fearful, sad, dispirited• Women who are aggressive without apparent cause• Prematurely-aged women• Dejected, humble women who express worthlessness or refer to themselves as stupid or incapable• Women who complain of unspecified pains, muscle contractions, numbness, intestinal or pelvic pains• Women with frequent headaches or insomnia• Women who complain of pain or experience no pleasure during sex or consider it a sacrifice. Expressions such as the following are typical of women subjected to frequent violence : "He uses me". "He relieves himself with me". "This is the cross you bear in marriage". "It's a woman's martyrdom".

OHT 10.7

Do's AND DONT'S RELATED TO GENDER-BASED VIOLENCE

Do's :

- ask
- express concern
- listen and validate
- offer help
- support her decisions

Dont's :

- judge or blame
- wait for her to come to you
- pressure her
- give advice
- place conditions on your support

OHT 10.8

SAFETY PLAN

1. Practice getting out of your home safely. Identify which window, or door would be best.
2. Whenever you believe that you are in danger, leave your home and take your children, no matter what hour of the day it is. Go to a friend or relative's house or a domestic violence shelter.
3. Devise a code word to use with your children, family, friends and neighbours when you need the police.
4. Plan where you will go if you have to leave home, even if you think you will not need to.
5. Have a packed bag ready and keep it in a secret but accessible place so that you can leave quickly.
6. Identify neighbours you can tell about the violence and ask them to call the police if they hear any disturbance coming from your home.
7. When an attack has begun, escape if you can.
8. Call for help, scream loudly and continuously. You have nothing to be ashamed of - the batterer does.
9. During an argument stay close to an exit and avoid being near the kitchen or anywhere near weapons.
10. Defend and protect yourself. Seek medical assistance for your injuries.
11. Trust your own instincts and judgment. Whatever you need to do to survive, is the right choice. You have the right to protect yourself.

CHAPTER 11

TRAINING FOR DOCUMENTATION AND RECORDING

The counsellors at the Information and Counselling Centre are required to keep a set of records. The purpose of these records is to (a) assess the work load and to see the trends in utilisation of the services (b) assess patient satisfaction (c) use the information generated from these records for training purposes, for example, unusual case studies can be used for training of student medical officers and other health care providers in the Continuing Medical Education sessions.

The following section describes each record and format and its use.

Recording tools used at the Centre include

1. Client Card
2. Records Register
3. Monthly report

Client Card

A Client Card is maintained for each client coming to the Centre for counselling. This is updated at each visit and provides a quick summary of the proceedings till date and enables the counsellor to identify those who fail to keep appointments and ensure a quick follow-up at their residences. However, a quick follow-up may not always be feasible and should be done considering the time factor and available human resources. Review of these cards over a period of time also contributes to assessment of the case handling/management as well as the usefulness of the services offered by the Centre. Cards may be maintained for at least three years as patients may come back. The format of the card is presented in Handout 8.5.

Records Register

The records register is maintained for the purpose of compilation of records. This register also serves as a data gathering tool and will be useful for generating a data bank regarding counselling needs related to gynaecological conditions and strategies that work and those that do not. The structure of the register is presented in Handout 11.1.

Monthly Report Format

A reporting format is developed for submitting the monthly report to the Medical Superintendent of the hospital and the Medical Officer of Health, in charge of the ward, where the Centre is located. Monthly compilation of data, analysis and drawing conclusions for implementation at their level also serves as a capacity building exercise for the staff at the Centre (Handout 11.2).



Process

A Client Card (Handout 8.5) is prepared for every new patient referred to the Centre for counselling and information purposes. After the counselling session, relevant information from the card is copied to the register (Handout 11.1). If a patient is asked to come for a follow up, all subsequent visits are marked on the register. Cards are arranged in the box files according to the serial numbers.

A monthly summary report (Handout 11.2) is submitted to the Medical Superintendent of the hospital and the Medical Officer of Health.

Module Objectives

- At the end of the session participants will
- describe each record/format and will be able to fill the same
 - state the purpose of the format, when to fill it, how to analyse the data yielded by each format periodically, and how to interpret and use the data for corrective action at their own levels
 - write reports based on the analysis, including suggestions for future action.

Session 1: Learning to fill the records and maintain reports at the counselling centre

Learning Objectives

- At the end of the session participants will be able to
- explain the purpose of filling the record sheets
 - fill the records and analyse the information

Time 1 hour

Resources Copies of three recording sheets (Handout 8.5, 11.1 and 11.2)

Methodology

1. The facilitator distributes the three recording sheets to the participants and asks them to read these.
2. Each item on the record sheet and its purpose is then discussed.
3. Participants fill the client card and social history form based on the data gathered in session 3 in the gynaecology chapter and reflect on it.
4. Questions regarding the filling of the forms are discussed and clarified.

CASE RECORD

Code No.
Case Paper Number

Case Serial Number

[illegible]

2. Intervention

[illegible]

3. Details of Referral

Date	Reason for referral	Refferal Centre

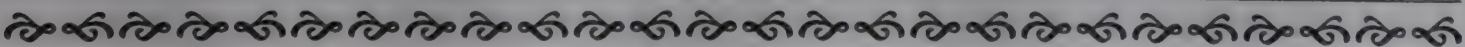
Specific information Needs Expressed by the Client, Client's Husband and Relative

Queries asked	Remarks

Discussion with Clinicians if any

Skills used

Problems faced by the guide



HANDOUT 11.2

MONTHLY REPORTING FORMAT

Name of the hospital : _____ Month : _____

1. Distribution of new and old patients regarding conditions for which counselling is sought

[illegible]

2. Distribution of new patients by source of referral

Sr. No.	Referred by	No.
1	Health Posts	
2	Dispensaries	
3	V N Desai Gynaecology OPD	
4	V N Desai Other OPDs	
5	Self referred	
6	Other	
	Total	

3. Details about patients who failed to keep a pre-determined appointment

a. Reasons for referral to centre

Reasons	No.

b. Number of house visits : _____

c. Number of patients contacted at home visits : _____

d. Reasons for failing to keep the appointment

Reasons	No.

e. Willingness to come to the Centre

Willing to come to Centre	No.
Yes	
No	

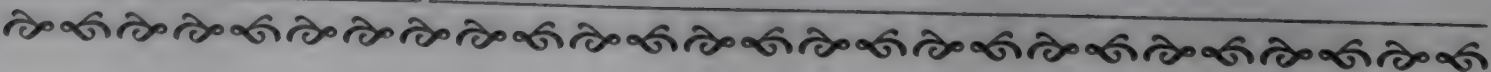
f. Number of those followed up at home who came to the Centre : _____

4. Details of patients referred

Reasons	Referral Centres				
					Total
Total					

5. Details of counselling to husbands / other family members :

Reason for counselling	Husband	Other relative



ANNEXURE I

TASK ANALYSIS OF STAFF AT GYNAECOLOGY OPD

This table contains the Task Analysis of the ANMs - MPWs who would be staffing the Information and Counselling Booth, as well as the doctors and nurses in the Gynaecology OPD. The ANMs' and MPWs' role is divided into A. Information Giving, B. Counselling, C. Link between the Doctor and the Patient, D. Training CHVs, and E. Documentation and Records keeping. Please note that the technical role of doctors and nurses in the gynaecology OPD is not included in this analysis.

ROLE	KNOWLEDGE	SKILLS	ATTITUDES
1. ANMs and MPWs			
A. Information Giving			
<ul style="list-style-type: none"> To answer all the queries of those who approach the Booth. 	About physical set up of the hospital- <ul style="list-style-type: none"> Names of Doctors, No. of departments. <ul style="list-style-type: none"> Facilities available Procedures for admissions, discharge, case papers, cost for taking treatment, working of departments and timings, respective OPDs specific days and timings List and location of Health Posts and facilities and staff (medical and paramedical) available at the Health Post. 	<ul style="list-style-type: none"> Clarifying doubts Clear Speech Listening 	<ul style="list-style-type: none"> Helpfulness Patience Dignity and worth of every Individual Respecting every individual

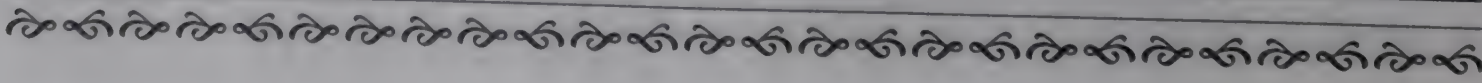
ROLE	KNOWLEDGE	SKILLS	ATTITUDES
(a) Self referred patients			
<ul style="list-style-type: none"> To identify the problem if the person comes directly to the Booth before visiting the doctor i.e. - self referral. 	<ul style="list-style-type: none"> Knowledge of technical and social aspects of gynaecological conditions Knowledge about the hospital set up 	<ul style="list-style-type: none"> Exploring Asking open-ended questions Clarifying doubts Listening Paraphrasing 	<ul style="list-style-type: none"> Helpfulness Patience Respect for another's dignity
<ul style="list-style-type: none"> To guide the person — with reference — to their problem 	<ul style="list-style-type: none"> Knowledge of technical and social aspects of gynaecological conditions 	<ul style="list-style-type: none"> Communication skills 	<ul style="list-style-type: none"> Patience Readiness to explain in simple and local language
<ul style="list-style-type: none"> To give information about her gynaecological problem / condition. To guide the person about consultation with the doctor during the current visit or when to come again, for example, end of her next menstrual period for the insertion of CU-T To suggest alternatives for getting consultations at the Health Post / Dispensaries. To guide the person to visit on appropriate days, timings and units. E.g. ANC women and patients from other units. 	<ul style="list-style-type: none"> Technical knowledge of Gynaecological problems /conditions, Family Planning methods, ANC, PNC, Nutrition, treatment and related procedures. Principles of effective communication Knowledge about the surrounding health posts / dispensaries, their functioning, timings and so on. Thorough knowledge of timings and locations of various OPDs, and procedures the woman would be required to complete at these OPDs 	<p>Communication skills -</p> <ul style="list-style-type: none"> Verbal Non-verbal (e.g. interpret silence and pauses of women) Observe body language Active listening Reading in- between the lines Using audio-visual material for giving information. 	<ul style="list-style-type: none"> Readiness to explain in simple and local language. Helpfulness Patience

ROLE	KNOWLEDGE	SKILLS	ATTITUDES
<i>(b) Referred by doctors in the gynaecology OPD</i>			
<ul style="list-style-type: none"> To look into the social problems related to the gynaecological condition of the patient and explore these in detail. To explain regarding operations and procedures. To discuss about options available in treatment which are suggested by the doctors. Explaining and preparing the patient for internal examination. To help patients who cannot make decisions of MTP/Family Planning methods. To refer the patient back to the doctor after explaining/giving information about treatment, examination and investigations. 	<ul style="list-style-type: none"> To look into the social problems related to the gynaecological condition of the patient and explore these in detail. To explain regarding operations and procedures. To discuss about options available in treatment which are suggested by the doctors. Explaining and preparing the patient for internal examination. To help patients who cannot make decisions of MTP/Family Planning methods. To refer the patient back to the doctor after explaining/giving information about treatment, examination and investigations. To have knowledge of different cultures and social condition of the patients Gender factors affecting health Problems of Poverty and under development and the politics of the third world countries; effects of social and economic policies on the lives of poor 	<ul style="list-style-type: none"> Rapport building Enabling Empathy Ventilation Communication and Counselling skills 	<ul style="list-style-type: none"> Acceptance Non-judgmental attitude Empathy Dignity and worth Individuality Gender sensitivity Sensitivity towards need for privacy and confidentiality Sensitivity to feelings of shyness, fear etc. associated with internal examination Sensitivity to the social, economic and cultural background of patients. Understanding need to be non-judgmental and non moralistic in relation to sexual issues Sensitivity to difficulties of women in taking decisions regarding use of FP

ROLE	KNOWLEDGE	SKILLS	ATTITUDES
	<ul style="list-style-type: none">• Technical knowledge of -Gynaecological problems /conditions, Family Planning methods, ANC, PNC, Nutrition, treatment and related procedures.• Family planning policies and programmes of the state• Politics of contraception and gender		<p>methods, MTPs , no. of children</p> <ul style="list-style-type: none">• Believing in women's ability and right to understand and take informed decisions• Patience to deal with non literate and rural patients
(c) Patients rejected by Doctors (in rare cases)			
<ul style="list-style-type: none">• Patients failing to keep the appointments given by the doctors.• Patients who have refused MTP/IUDs		<ul style="list-style-type: none">• Rapport building• Active listening• Empathy• Exploring facts for non-compliance	<ul style="list-style-type: none">• Woman Centeredness-seeing things from woman's perspective• Self-esteem• Self respect• Informed decision making
(d) Follow-up visits			
<ul style="list-style-type: none">• To guide the person and provide information on procedures like hydrotubation• To check whether the patient has brought all the required reports of investigations advised by the doctors in the first visit.	<ul style="list-style-type: none">• Technical knowledge of the related disease conditions, Family Planning methods, ANC, PNC, Nutrition, Treatment and related procedures.• Principles of effective communication	<p>Communication skills -</p> <ul style="list-style-type: none">• Verbal• Non-verbal (e.g. interpret silence and pauses of women)• Observe body language• Active listening• Reading in-between the lines• Using audio-visual material for giving information.	<ul style="list-style-type: none">• Acceptance• Readiness to explain in simple and local language

ROLE	KNOWLEDGE	SKILLS	ATTITUDES
B. Counselling			
	<ul style="list-style-type: none"> Principles and Values in Counselling Knowledge about different theories of counselling 	<ul style="list-style-type: none"> Active Listening Ventilation Empathy Enabling Reflecting Paraphrasing Summarising Focusing Ability to challenge and confront Goal setting Involving patient in decision making Self awareness 	<ul style="list-style-type: none"> Unconditional acceptance Individuality Non-judgmental Dignity and worth of an individual Self-determination Confidentiality Warmth and Genuineness Sense of humour
C. Link between the patient and the Doctor			
<ul style="list-style-type: none"> Information gathering - facts from patients about their condition and findings from the doctor, and then to communicate to the patients. Sensitising doctors about socio-economic and cultural situation of the patients and encourage doctors to act accordingly. 	<ul style="list-style-type: none"> Information gathering - facts from patients about their condition and findings from the doctor, and then to communicate to the patients. Sensitising doctors about socio-economic and cultural situation of the patients and encourage doctors to act accordingly. 	Interviewing skills <ul style="list-style-type: none"> Attending Exploring Listening Observing Reflecting Empathy 	<ul style="list-style-type: none"> Acceptance Non-judgmental Individuality Self-determination Dignity and worth Patience Helpfulness

ROLE	KNOWLEDGE	SKILLS	ATTITUDES
<ul style="list-style-type: none">• Case presentation to doctors in regular CMEs.• Psychologically preparing patient and patient's family for operation and procedures• Convincing the patient and patient's family for hospitalisation.• To confirm whether the patient has understood doctor's instructions regarding medicines, treatment and instructions given on sensitive issues like sexual problems.• Work with patient's husband if recommended by the doctor.	<ul style="list-style-type: none">• Case presentation to doctors in regular CMEs.• Psychologically preparing patient and patient's family for operation and procedures• Convincing the patient and patient's family for hospitalisation.• To confirm whether the patient has understood doctor's instructions regarding medicines, treatment and instructions given on sensitive issues like sexual problems.• Work with patient's husband if recommended by the doctor.• How to ask open- ended questions.• How to probe and explore questions.• Knowledge of cultural and social condition of the patient• To be clear about objectives, complete knowledge of the case.• Knowledge about the family, and also about interpersonal relations in the family.• Knowledge of the disease condition and also about their family culture and status in the society.	<ul style="list-style-type: none">• Building relationships.Presentation skills• Logical flow while presenting• Clear speech.• Soft and convincing tone of voice• Convince the patient and explain the importance of the treatment, and the procedure.• Counselling skills	<ul style="list-style-type: none">• Patience• Willingness to explain over and over again• Commitment to explain things in different ways



ROLE	KNOWLEDGE	SKILLS	ATTITUDES
D. Training the CHVs			
<ul style="list-style-type: none"> To do follow-up in the community. To identify women/couples needing counselling and/or information and refer to Health Post, NGOs, hospitals etc. Exploring facts about family conditions.(socio-economic-cultural) Explore facts about husband - wife relations if required. 	<ul style="list-style-type: none"> To do follow-up in the community. To identify women/couples needing counselling and/or information and refer to Health Post, NGOs, hospitals etc. Exploring facts about family conditions.(socio-economic-cultural) Explore facts about husband - wife relations if required. Principles of adult learning 	<ul style="list-style-type: none"> Participatory Training Skills. 	<ul style="list-style-type: none"> Sharing of knowledge and skills is important for empowerment of others.
E. Documentation and Record Keeping			
<ul style="list-style-type: none"> Maintain daily diaries. Case records. Monthly reports. Prepare case studies for training purpose and CMEs. 	<ul style="list-style-type: none"> Maintain daily diaries. Case records. Monthly reports. Prepare case studies for training purpose and CMEs. Knowledge of general administration: to keep and maintain records, regularity and consistency in keeping records Know the objective of maintaining records. 	<ul style="list-style-type: none"> Skills of writing neatly and completely Analytical skills Skills of abstraction. 	<ul style="list-style-type: none"> Commitment to meticulous and authentic recording Woman centeredness (seeing things from woman's perspective)

ROLE	KNOWLEDGE	SKILLS	ATTITUDES
2. Doctors in the gynaecology OPD			
<ul style="list-style-type: none"> • History taking • Preparing for internal examination • Information provision on all aspects. • Referring to the Booth <ul style="list-style-type: none"> * In case the patient or the doctor needs to discuss sensitive issues like sexual problems * In case women not willing or not cooperating for the examination * In case patient expresses inability to follow the instructions or line of treatment * In case patient has failed to follow up on the date advised/ or to understand reasons behind non-compliance * In case of MTP or FP methods—patients unable to decide * Preparing patients for procedures and operations * In case they identify social problem related to the condition * Indicate on the case paper if the booth staff should talk to her family members including husband 	<ul style="list-style-type: none"> • Socio-economic factors affecting reproductive and sexual health • Sexuality and reproductive health • Gender analysis of health system, policies, programmes and services • Problems of Poverty and under development and the politics of the third world countries; effects of social and economic policies on the lives of poor • Family planning policies and programmes of the state • Politics of contraception and gender • Socio-economic , cultural , gender issues affecting women's reproductive and sexual health • Functioning of the HP and the Dispensaries and the role of outreach worker 	<ul style="list-style-type: none"> • Communication skills <ul style="list-style-type: none"> – Eye contact – Understanding Verbal and Non-verbal communication (interpreting silences, pauses) – Observing body language – Active listening – Probing for knowing the reality and facts – Use of simple and local language – Maintaining verbal and non-verbal privacy in the available resources; talking softly during internal examination. and giving information, 	<ul style="list-style-type: none"> • Acceptance • Non-judgmental attitude • Empathy • Dignity and worth • Individuality • Gender sensitivity • Sensitivity towards need for privacy and confidentiality • Sensitivity to feelings of shyness, fear and so on associated with internal examination • Sensitivity to the social, economic and cultural background of patients. • Understanding need to be non-judgmental and non-moralistic in relation to sexual issues • Sensitivity to difficulties of women in taking

ROLE	KNOWLEDGE	SKILLS	ATTITUDES
<ul style="list-style-type: none"> • Checking for referral from the booth staff, regarding patient's socio-economic, cultural background if it is relevant for managing the case • Share information regarding patient's conditions/admission with the booth staff • Understand the socio-economic, cultural barriers for treatment, and plan alternative action along with the booth staff • Indicate which patients could be referred to the HP/Dispensary for follow-up • Attend case presentations made by the booth staff and discuss difficulties they had in dealing with patient's problems e.g.related to information, compliance etc. • Train the booth staff in technical matters (knowledge about conditions, referrals, procedures and admission , investigations and discharge procedures and help in preparing the resource material e.g. case studies) 		<p>instructions about sexual relations and issues</p> <ul style="list-style-type: none"> • Making the patient comfortable (use of bedside manners) • Training skills 	<p>decisions regarding use of FP methods, MTPs , no. of children</p> <ul style="list-style-type: none"> • Believing in women's ability and right to understand and take informed decisions • Patience to deal with non-literate and rural patients • Willingness and openness to learn from the experiences of the booth and the outreach staff • Sharing of knowledge and skills is important for empowerment of others and helps in multidisciplinary approach

ROLE	KNOWLEDGE	SKILLS	ATTITUDES
3. Nurse in the gynaecology OPD			
<ul style="list-style-type: none"> • Answer all queries • Guidance regarding procedures, investigations, working of the hospital • Information -giving • Directing patients for follow-up visits and for consulting the doctor • Checking whether patient has completed all the required investigations • Management of logistics - Curtains and draw sheet for privacy • Be present at the time of internal examination , give instructions and make the patient comfortable • Attend to patients referred by the doctors for explanations regarding operations, procedures • Discuss treatment options with the patient 	<ul style="list-style-type: none"> • Socio-economic, cultural, gender issues affecting women's reproductive and sexual health • Sexuality and reproductive health • Gender analysis of health system, policies, programmes and services • Problems of Poverty and under development and the politics of third world countries; effects of social and economic policies on the lives of poor • Family planning policies and programmes of the state • Politics of contraception and gender 	<ul style="list-style-type: none"> • Communication skills <ul style="list-style-type: none"> - Eye contact - Understanding Verbal and Non verbal communication (interpreting silences, pauses) - Body language - Active listening - Probing for knowing the reality and facts - Use of simple and local language - Maintaining verbal and nonverbal privacy in the available resources (talking softly during internal examination and giving information, instructions about sexual relations and issues • Making the patient comfortable (use of bed-side manners) 	<ul style="list-style-type: none"> • Acceptance • Non-judgmental attitude • Empathy • Dignity and worth • Individuality • Gender sensitivity • Sensitivity towards need for privacy and confidentiality • Sensitivity to feelings of shyness, fear and so on associated with internal examination • Sensitivity to the social and cultural sanctions to sexual issues • Sensitivity to inability of women in taking decisions regarding use of FP methods, MTPs , no. of children and so on • Patience to deal with non literate and rural patients

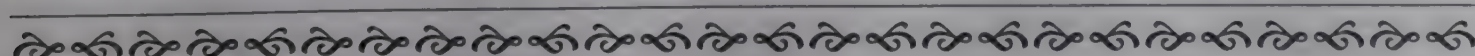
ANNEXURE II

DESIGN OF THE 4- DAY COUNSELLING WORKSHOP FOR ANMs AND MPWs

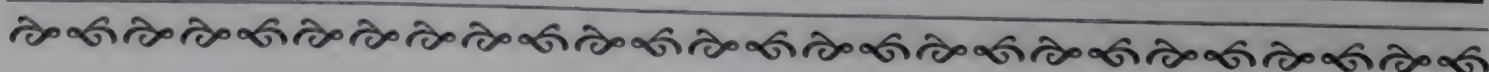
Objectives

- To familiarise the participant health care providers to the principles of counselling and skills required for counselling

Session Topic	Contents	Time	Methodology
Day 1			
1. Ice breaker and introduction	<ul style="list-style-type: none"> Ice breaker exercises 	30 minutes	<ul style="list-style-type: none"> Ice breakers and games
2. Pre-test questionnaire	<ul style="list-style-type: none"> Pre-test questionnaire 	30 minutes	<ul style="list-style-type: none"> Questionnaire
3. Gender and sexuality	<ul style="list-style-type: none"> Gender and Sex Implications of gender in terms of power and decision-making framework Gender and health – RH 	2 hours	<ul style="list-style-type: none"> Pictures of gender stereotypes Lecture and discussion Gender analysis framework
4. Sensitivity in counselling and qualities of a counsellor	<ul style="list-style-type: none"> Qualities desirable in a counsellor 	1 hour	<ul style="list-style-type: none"> Exercise
5. Self realisation	<ul style="list-style-type: none"> Self evaluation for openness, getting feedback and sensitivity 	30 minutes	<ul style="list-style-type: none"> Questionnaire
6. Communication skills	<ul style="list-style-type: none"> Verbal and non-verbal communication and skills required for effective communication 	30 minutes	<ul style="list-style-type: none"> Lecture Role play Discussion
7. Errors in counselling	<ul style="list-style-type: none"> Do's and Don'ts in counselling in terms of principles and values 	20 minutes	<ul style="list-style-type: none"> Role play Discussion Lecture
8. Macro and micro skills in counselling	<ul style="list-style-type: none"> Macro and micro skills in counselling 	1 hour 15 minutes	<ul style="list-style-type: none"> Lecture Role play Discussion Exercise for converting close ended questions to open-ended questions
Day 2			
9. High risk ANC and hysterectomy	<ul style="list-style-type: none"> Technical aspects of high risk ANC and hysterectomy 	2 hours	<ul style="list-style-type: none"> Question - answer Lecture



Session Topic	Contents	Time	Methodology
	<ul style="list-style-type: none"> Gender and sexuality in reference to high risk ANC and hysterectomy Men's role in ANC and hysterectomy Concept of violence 		
10. Violence and health	<ul style="list-style-type: none"> Violence as a health issue and its consequences Skills required for counselling of survivors of violence Sexuality 	1 hour 30 minutes	<ul style="list-style-type: none"> Brain storming Group work Presentation
11. Sexuality and health	<ul style="list-style-type: none"> Relevance of sexual practices in gynaecological conditions 	2 hours	<ul style="list-style-type: none"> Exercises on attitude towards sexuality Discussion Presentation
12. Information needs of clients	<ul style="list-style-type: none"> Information needs of clients 	45 minutes	<ul style="list-style-type: none"> Exercise
Day 3			
13. Practical experience of working with clients visiting the gynaecology OPD	<ul style="list-style-type: none"> Skills required for counsellors 	3 hours 30 minutes	<ul style="list-style-type: none"> Practical experience at various departments of hospital
		1 hour 30 minutes	<ul style="list-style-type: none"> Group work
14. Effective use of IEC material in gynaecological counselling	<ul style="list-style-type: none"> Importance of use of IEC material in counselling 	1 hour	<ul style="list-style-type: none"> Exercises Demonstration of condom use Role play
15. Demonstration of counselling skills	<ul style="list-style-type: none"> Verbal, non-verbal, macro and micro skills 		<ul style="list-style-type: none"> Discussion
Day 4			
16. MTP and contraception	<ul style="list-style-type: none"> Technical aspects of MTP and contraception Importance of informed choice Gender and sexuality issues related to MTP and contraception 	2 hours	<ul style="list-style-type: none"> Question/answer Lecture
17. Recording counselling cases	<ul style="list-style-type: none"> Documentation of counselling cases 	30 minutes	<ul style="list-style-type: none"> Practice session for filling in forms
18. Practicing counselling skills	<ul style="list-style-type: none"> Demonstration of counselling skills by trainees 	2 hours	<ul style="list-style-type: none"> Role play
19. Evaluation and post-test questionnaire	<ul style="list-style-type: none"> Evaluation and post- test 	30 minutes	<ul style="list-style-type: none"> Questionnaire



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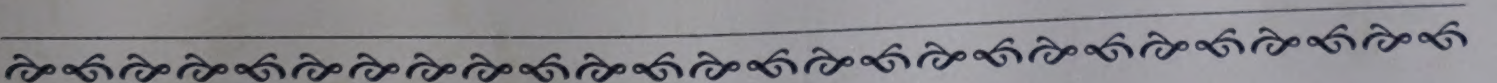
Vidya Lad

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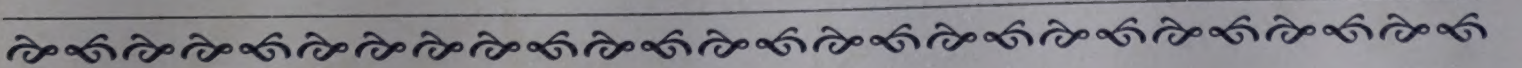
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